Geriatric Care Management: A Robust Model of Care

LeadingAge Iowa

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Learning Objectives:

- Gain an understanding of the current evidence-based models of care management across the continuum including integrated longitudinal and transitional care management models.
- Identify key quality and outcome measures to support value-based care.
- Identify opportunities for long-term care providers to develop robust care management models to leverage service lines and partnerships across the care continuum.

Today's Discussion

- Need for Care Management
- Establishing effectiveness
- Evidence-Based Interventions
- Improving Outcomes and Reducing Costs
- Opportunities in the Post-Acute Care continuum
Need for Care Management
Defining the Problem

Why do we need good care management?

- A small number of individuals with complex chronic conditions account for most health care dollars
- High costs and health care utilization is caused by:
  - Poor communication among primary providers, specialists, health and community providers, patients, and families
  - Failure to catch problems early
  - Failure to address psychosocial issues
  - Lack of coordinated, longitudinal care management
  - Ineffective transitional care management
  - Insufficient management of multiple medications
  - Deviations from evidence-based care

We can do better

Poorly Managing Chronic Conditions is Costly

Nearly three-quarters of Medicare spending is for people with five or more chronic conditions

The More Complex the Needs the More Costly

50% of total Medicaid spending is driven by 5% of beneficiaries

80% of high-cost Medicaid beneficiaries have three or more chronic conditions

60% have five or more chronic conditions

Source: Robert Wood Johnson Foundation

Chronic Conditions Lead to Increased Hospital Admissions and Health Care Utilization

- This high utilization and cost is driven by:
  - Poor communication among primary providers, specialists, health and community providers, patients, and families
  - Failure to catch problems early
  - Failure to address psychosocial issues
  - Lack of coordinated, longitudinal care management
  - Ineffective transitional care management
  - Insufficient management of multiple medications
  - Deviations from evidence-based care

Source: Academy Health 2012

Improved Chronic Care Management can Produce Health Care Savings

Potential Net National Health Care Expense Savings Over 10 Years

$306 billion

Early Lessons Learned
Establishing Effectiveness

Medicare Care Coordination Demonstration

In-depth analysis of programs identified six consistent constructs in effective programs:
• Only 3 of 15 Medicare Care Coordination Demonstration programs were effective in reducing hospitalizations and costs over first 4 years
• Those that were effective had consistent core constructs:
  – Targeting those who will benefit most
  – In-person contact
  – Access to timely information on hospital and emergency room admissions
  – Close interaction between care coordinators and primary care physicians
  – Common core services provided
  – Identification and consistency of care coordinator

Source: Report for National Coalition of Care Coordination, Mathematica Policy Research, 2009 Medicare Coordination Care Demonstrations

In-Person Contact with Patients

• Successful interventions had substantial amounts of in-person contacts
• Patients averaging nearly one in-person contact per month
• Many of these contacts were by telephone
Access to Timely Information on Hospital and Emergency Room Admissions

- Learning about acute episodes shortly after they occur is a crucial factor.
- Patients are particularly vulnerable for readmissions after a hospitalization or emergency room visit.
- This provides an opportunity to explain how better adherence and self-care may prevent such occurrences.

Close Interaction Between Care Coordinators and Primary Care Physician

- Two primary factors affect the strength of the relationship:
  - The opportunity to interact face-to-face on occasion.
  - Having the same care coordinator working with all the program patients for a given primary care physician.

Evidence-Based Interventions

Key Components
Transitional Care Management

“A set of time-limited activities designed to coordinate healthcare a patients move between different locations or levels of care, typically from hospital to home.”

The American Society on Aging

Care Management

“A person-centered, assessment based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.”

The National Coalition on Care Coordination (NCC)

Care Management Models Must Prove Value

- Rigorous evidence that there is a direct cause and effect between an interaction and an outcome
- Evidence-based care management must:
  - Improve beneficiary outcomes
  - Reduce total health care expenditures for participating beneficiaries

“No consensus exists about a successful transition intervention that improves care quality and lowers costs”

American Society on Aging 2013
Successful Models Target Those who will Benefit Most from Care Management

Those most likely to benefit from care management interventions are patients at substantial risk of hospitalization in the coming year, but not necessarily those with the greatest risk for repeated hospitalizations.

Risk Stratification

Populations are not homogenous, especially seniors.

- **Healthy Seniors**
  - Goal: Maintain independence
  - Prevent chronic illness

- **Chronic Disease**
  - Goal: Manage illness
  - Aggressive primary care

- **Frail, At Risk**
  - Goal: Avoid high cost setting
  - Maintain quality of life

Each cohort requires a different care management strategy.

Interventions

Three types of interventions have demonstrated effectively reducing hospitalization for Medicare beneficiaries with multiple conditions.

- Few single programs have combined all three types of interventions.
Transitional Care Model Components

• These programs:
  – Engage patients with chronic illnesses while hospitalized
  – Follow patients intensively post-discharge
  – Teach/coach patients about medications, self-care, and symptom recognition and management
  – Remind and encourage patients to keep follow-up physician appointments
• Approaches to achieving these goals differ across programs

Care Management Components

• Interventions have common components:
  – Interdisciplinary team care with designated care managers who are advance practice nurses, RNs, social workers, occupational therapists, and other rehabilitative specialists (the most successful teams to date are those managed by RNs)
  – Frequent face-to-face patient contact in the clinical, hospital, and home settings
  – Regular phone monitoring
  – Relatively small patient caseloads
  – Psychosocial assessment combined with mental health and social support services as needed

Care Management Components (continued)

• Interventions share the following activities and practices:
  – Use evidence-based practice guidelines for care management
  – Conduct a comprehensive, multidimensional in-home initial assessment
  – Medication review and reconciliation
  – Develop a collaborative plan of care – and a specific action plan and goals – with the patient, their caregiver, and primary care provider
  – Implement self-care, coaching, and support, and an effective medication management plan with the patient and their caregiver
  – Facilitate communication among the patient’s providers about the patient, as well as between the patient and their providers
  – Manage transitions with a timely comprehensive response to care setting changes, especially from hospitals and skilled nursing facilities
  – Arrange and coordinate needed health- and community-related support services
Common Core Services

- All the successful programs focus their interventions on:
  - Assessing
  - Care planning
  - Educating
  - Monitoring
  - Coaching patients on self-management

- Teaching patients how to take their medications properly was a distinguishing factor for successful programs.
- Arranging for social supports and assistance with activities of daily living, transportation, or overcoming isolation was also part of a successful program.

Identification and Consistency of the Care Coordinator

- Matching the individual’s needs and the care coordinator’s skill set.
- Many care coordination interventions rely on registered nurses to deliver the bulk of their interventions, with each patient assigned to a particular nurse coordinator to create rapport and preserve continuity with both the patient and the primary care physician.
- Social workers also provide valuable assistance for some patients assessing eligibility and arranging LTSS services.

<table>
<thead>
<tr>
<th>Individual’s Most Prominent Needs</th>
<th>Care Coordinator Skill Set</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Medical frailty or complexity</td>
<td>Nurse</td>
</tr>
<tr>
<td>Social instability or lack of social support</td>
<td>Social Worker or Community Health Worker</td>
</tr>
</tbody>
</table>

Elements of Effective Care Models

- Care coordinator available for medical advice 24/7
- Patient education and compliance management
- Close coordination during transitions between care settings
- Centralized health records available to all care providers 24/7
- Tight integration between care coordinators, primary care, and specialty physicians

Source: Ken Thorpe, Emory University, September 2011; www.healthandwelfare.idaho.gov/Portals//Medical/ManagedCare/EstimatedSavingsfromCareCoordination.pdf
Emerging Models

Care Transitions Intervention
- CTI
- Coleman, University of Denver

Transitional Care Model
- TCM
- Naylor

Geriatric Resources for Assessment & Care of Elders
- GRACE
- Counsell, Indiana University

Emerging CMS Initiatives and Innovations
- Community-based Care Transitions Programs (Person-centered Health Homes; Medicaid/LTIS Managed Care)
- Community Care of North Carolina

Care Transitions Intervention (CTI)
Coleman, University of Denver

- Program initiated prior to hospital discharge, continues four weeks post discharge
- Transition coach:
  - Meets with patient in hospital
  - Home visit 48–72 hours post discharge
  - Telephone consultations (2–3) within first 30 days post discharge
- Transition coach’s focus: skill transfer for how to handle common transition-related challenges
- Resource: http://www.caretransitions.org/

CTI Model Key Components

- Designation of accountable clinician
- Medication discrepancies: reconcile pre-discharge from SNF
- Medication education: self-administration
- Home and care needs assessment
- Discharge instructions and teach-back with resident and care providers post discharge (red flags)
- Scheduled call-back or check-ins post discharge
- Schedule follow up with physician PRIOR to discharge
- Pre-discharge care meeting with all providers
The Transitional Care Model (TCM) Naylor

- Nurse-led, multidisciplinary approach
- Single point person across care settings
- Focus on patient empowerment
- Streamlined plan of care
- Intervention estimated for two months
- Resource: http://www.transitionalcare.info

TCM Model Key Components

- Designation of nurse case manager for coordination of care pre-admission through 60 days post discharge or admission to LTC
- Implementation of evidence-based care maps and protocols
- Streamline plan of care to focus on key short- and long-term self-care issues
- Expand resident education and self-care during post-acute care admission
- Monitor and educate care providers and resident on early symptoms of disease exacerbations and interventions to prevent hospital and ED admissions

Geriatric Resources for Assessment & Care of Elders (GRACE) Counsell, Indiana University

- In-home assessment and care management by NP/SW team in collaboration with the primary care physician
- Extensive use of specific care protocols for evaluation and management of common geriatric conditions
- Documentation in an integrated EMR
- Use of a Web-based care management tracking tool
- Integration with affiliated pharmacy, mental health, hospital, home health, and community-based services

GRACE Model Key Components

• Communicate baseline status and care plan
• Collaborate in planning transition
• Deliver transitional care, including home visit
• Proactive support of patient and family/caregiver
• Reconcile medications and provide new medication list
• Ensure post-discharge arrangements implemented
• Inform PCP and schedule follow-up visit

Community Care of North Carolina

• Statewide comprehensive medical management working with 1,325 primary care medical homes and 120 hospitals
• Face-to-face self-management education for patients and families
• Timely outpatient follow-up with medical home that has been fully informed about the hospitalization and any clinical or social issues that complicate the patient’s care
• Intensity of intervention was determined by case manager’s assessment of need (one-, three- and six-month duration)
• Medicaid-only population

Community Care Key Components

• Established protocols can be flexible and still show positive outcomes if tailored to specific patient needs
  – LOW intensity: assessment showing no further support needed, follow-up phone call to confirm
  – MODERATE intensity: service coordination, medication reconciliation
  – HIGH intensity: in-home visit, comprehensive medication review
• Transition care can delay the first rehospitalization but also the second and third
Improving Outcomes and Reducing Costs
Successful Models

Evidence-Based Models Show Results: CTI Rehospitalization Rates

Percent of Patients Rehospitalized

- At 30 Days
  - CTI Group: 8%
  - Control Group: 12%

- At 90 Days
  - CTI Group: 23%
  - Control Group: 31%

- At 180 Days
  - CTI Group: 26%
  - Control Group: 31%

TCM’s Impact on Readmission Rates After Index Hospitalization

Percent of Patients Rehospitalized

- At 6 Weeks (1)
  - TCM Group: 10%
  - Control Group: 23%

- At 6 months (2)
  - TCM Group: 28%
  - Control Group: 56%

- At 1 year (3)
  - TCM Group: 48%
  - Control Group: 61%

References:

GRACE Model Rehospitalization Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>705</td>
</tr>
<tr>
<td>Year 2</td>
<td>396</td>
</tr>
<tr>
<td>Year 3</td>
<td>370</td>
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Community Care of North Carolina Rehospitalization Rates

<table>
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<tr>
<th>Number of Readmissions per 1,000 Medicaid Recipients</th>
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<tbody>
<tr>
<td>30 day readmissions</td>
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<tr>
<td>60 day readmissions</td>
</tr>
<tr>
<td>90 day readmissions</td>
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Source: Jackson, et al. Transitional Care Cuts Hospital Readmissions for North Carolina Medicaid Patients with Complex Chronic Conditions, August 2013.

Opportunities

Opportunities in the Post Acute Care Continuum
Potential Partners in Health Care Reform

What Success Factors Can You Bring?
Partnerships must be value-based: what do you bring to the table?
- Hospital readmission reduction or LOS management
- Capability to manage medically complex, not just rehab
- Embedding primary care in SNF, AL, and IL
- Cost management for patient episode of care
- Care coordination across the continuum
- Chronic care management to reduce ED visits and hospitalizations
- Electronic information exchange
- Ability to share payment risk based on outcomes

Internal Evidence
- Achieving model consistency
  - Comprehensive and ongoing care coordinator training
  - Evidence-based practice guides established and updated
- Feedback provided to care coordinators on implementation of these guidelines
- Tracking of and feedback to care managers on established contacts
- Tracking and reporting amount of time care coordinator spends on tasks
- Established methods to measure fidelity and generate feedback
External Evidence

• Effects:
  – Hospital admissions and readmissions
  – Medical costs
    • By service
    • Total
  – Return on investment
    • Did savings exceed intervention costs?
  – Quality of care indicators
    • Screenings, preventive care, ER visits, infections, falls, mortality, etc.

Care Management Addresses the Triple Aim of Population Health

• Improving Outcomes
• Reducing Costs
• Improving the Patient Experience

Questions?