Making it Safe to Grow Old & Frail: The Medicaring™ Reform

Joanne Lynn, MD, MA, MS
Director, Center for Elder Care and Advanced Illness
Single Classic “Terminal” Disease

- Onset of incurable disease
- Time
- -- Often a few years, but decline usually < 2 months

Function

High

Low

Death
Organ System Failure (mostly heart and lung)

- High Function
- Low Function

Begin to use hospital often, self-care becomes difficult

~ 2-5 years, but death usually seems “sudden”

Death

Time
Dementia/Frailty

Time

Onset could be deficits in ADL, speech, ambulation

Quite variable - up to 6-8 years

Death
What We Want in Old Age….
While old age may always be challenging, we have made it unnecessarily terrifying and miserable.
What’s Wrong with Medical Services?

▲ Clinicians assume that strategies developed for 55 year olds work for 90 year olds – but – lower resilience, less energy, smaller reserves, shorter time frame for returns
▲ Also assume that clinician roles are central – ignore relationships
▲ Treatment plans, but rarely comprehensive care plans
▲ Inattention to burden (patient and caregivers), comfort, delirium, depression, and dementia – and finances
▲ Little honest prognostication – often even the physicians lack knowledge of the future (survival, function, costs)
▲ Few clinicians become expert in geriatrics care, or know principles
▲ Rare evaluation or feedback on performance
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
% Change 1950 - 2003
Population by Age Group
U.S. consumption \((private + public)\)

Y axis, 1 = Average Labor Income Ages 30-49

How are we going to keep from big trouble?
Assure that Americans can live comfortably and meaningfully at a sustainable cost through the period of frailty that affects most of us in our last years.
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

Median survival from 1st interview
With 2 or more ADL – almost 3 yrs.
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
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**

Unless Opt Out

**Age >85**

Want a sensible care system

With Opt In

Age >85
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
A Good Care Plan
How important is it?

A good care plan at all times is the keystone of good care.

Services without a plan are reactive, dangerous, and terrifying.
What’s essential in developing a good care plan?

▲ Thorough understanding of the patient/family situation

▲ Reasonable prognostication of how things will turn out for “patient” and “family” with various strategies

▲ Accurate knowledge of the availability and acceptability of services

▲ Effective communication, sensitive but honest, timely and evolving

▲ Patient (and family) priorities, fears and hopes

▲ Involvement of all key service providers (perhaps asynchronously)

▲ Discussion/negotiation - Addressing all critical issues, making compromises, accepting risks, using time-limited trials

▲ Setting time and event triggers for re-evaluating

▲ Documenting (especially for transitions in care team and setting)
Historical & Projected Numbers of Medicare Beneficiaries and Workers per Beneficiary

Number of Beneficiaries (in millions)

- 1966: 19
- 1970: 20
- 1990: 34
- 2000: 40
- 2010: 47
- 2020: 64
- 2030: 80

Number of Workers Per Beneficiary

- 2000: 4.0
- 2007: 3.8
- 2010: 3.4
- 2020: 2.8
- 2030: 2.3

And then evaluate

▲ For individuals –
  ▪ Presence
  ▪ Known by all affected, continues across settings, implemented
  ▪ Satisfaction with the process
  ▪ Patient/client report: helping to pursue goals
  ▪ Patient/client report of confidence
  ▪ Outcomes (life lived) evaluated against priority values

▲ For systems –
  ▪ Regular performance for individuals
  ▪ Feedback upstream – self-correcting process
  ▪ [use of care plans to manage the service supply and quality]
About Customized Service Plans

Articulated Values

Goals

Plan

Integration

Implement

Feedback

Feedback

Evaluation of Quality

Outcomes
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
## Flowsheet Report

**Select Flowsheets to View**

**LIFECOURSE GOAL MANAGER [125]**

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>LifeCourse Goal 1 Description</td>
<td>Continue volunteering with</td>
<td>Continue volunteering with</td>
<td>Continue volunteering with</td>
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<tr>
<td>LifeCourse Goal 1 Importance</td>
<td>Physical; Social; Psychological</td>
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<td>Physical; Social; Psychological</td>
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<td>LifeCourse Goal 1 Domain</td>
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<td>Inactive</td>
<td>Inactive</td>
</tr>
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<td>LifeCourse Goal 1 Plan</td>
<td>has officially retired</td>
<td>has disengaged from</td>
<td></td>
</tr>
<tr>
<td>LifeCourse Goal 2 Description</td>
<td>Stay active, walk as much as possible</td>
<td>Stay active, walk as much as possible</td>
<td></td>
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<tr>
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<td>High</td>
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<td>LifeCourse Goal 2 Plan</td>
<td>is no longer able to</td>
<td>has been walking better</td>
<td></td>
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<tr>
<td>LifeCourse Goal 3 Description</td>
<td>I want to spend as much time with my family</td>
<td>I want to spend as much time with my family</td>
<td>I want to spend as much time with my family</td>
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<tr>
<td>LifeCourse Goal 3 Importance</td>
<td>High</td>
<td>High</td>
<td>High</td>
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<td>Physical; Social; Psychological</td>
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<td>Active</td>
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<td>LifeCourse Goal 3 Status</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
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<tr>
<td>LifeCourse Goal 3 Plan</td>
<td>sees her family regularly</td>
<td>talks about her family</td>
<td></td>
</tr>
<tr>
<td>LifeCourse Goal 4 Description</td>
<td>enrolled in hospice care</td>
<td>enrolled in hospice care</td>
<td>enrolled in hospice care</td>
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<tr>
<td>LifeCourse Goal 4 Importance</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
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Geriatricize Medical Care
Guided Care®
“It’s like having a nurse in the family”

Chad Boult, MD
Lipitz Center for Integrated Health Care
Johns Hopkins Bloomberg School of Public Health
<table>
<thead>
<tr>
<th></th>
<th>Guided Care® 8 RN Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Assessment of patient at home</td>
</tr>
<tr>
<td>2.</td>
<td>Create an evidence-based Care Guide</td>
</tr>
<tr>
<td>3.</td>
<td>Monitor the patient proactively</td>
</tr>
<tr>
<td>4.</td>
<td>Empower the patient; encourage self-management, including early identification of worsening symptoms</td>
</tr>
<tr>
<td>5.</td>
<td>Coordinate care</td>
</tr>
<tr>
<td>6.</td>
<td>Smooth patient transitions between home, hospital and other facilities</td>
</tr>
<tr>
<td>7.</td>
<td>Educate and support caregivers</td>
</tr>
<tr>
<td>8.</td>
<td>Access community resources</td>
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</table>
Guided Care® Results

- 24% reduction in total hospital inpatient days
- 15% fewer ER visits
- 37% decrease in skilled nursing facility days
- Annual net Medicare savings of $75,000 per Guided Care nurse deployed in a practice
GRACE – Geriatric Resources for Assessment and Care of Elders

Steven R. Counsell, MD
University of Indiana

RCT to test effectiveness of a geriatric care management model on improving quality of care for low-income seniors in primary care

JAMA. 2007;298(22):2623-2633
GRACE High-risk enrollees subset

- Fewer visits to ED
- Fewer hospitalizations
- Fewer readmissions
- Reduced hospital costs
- GRACE intervention saved $1,500 per enrolled high-risk patient by the second year
- High ratings by physicians
- Reported higher quality of life compared with control group
PACE - Program for All-inclusive Care of the Elderly

Provides full continuum of preventive, primary, acute, and long term care services in medical/social model. Capitated PMPM payment from Medicare and Medicaid
PACE Services

- Adult day care with care plan developed by interdisciplinary team of professionals
- Transportation to PACE center
- Medical care by PACE physician
- Home health care including personal care
- All necessary prescription drugs
- Social services
- Medical specialists as needed
- Respite care
- ED, hospital and nursing home care when needed
Fewer Hospitalizations Result When Primary Care Is Highly Integrated into a CCRC

Julie P.W. Bynum, Alice Andrews, Sandra Sharp, Dennis McCollough and John E. Wennberg
Health Affairs. 2011;30(5):975-984
<table>
<thead>
<tr>
<th>Site</th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
<th>Site D</th>
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<tbody>
<tr>
<td>Site A</td>
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<tr>
<td>Site A</td>
<td>Site B</td>
<td>Site C</td>
<td>Site D</td>
<td></td>
</tr>
<tr>
<td>Site A</td>
<td>Site B</td>
<td></td>
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</tr>
</tbody>
</table>

**Resident receiving primary care on site (%)**
- Site A: 90%
- Site B: 80%
- Site C: 95%
- Site D: 98%

**On-site nurse practitioners**
- Site A: 1 full time
- Site B: 1 full time
- Site C: 1 full time
- Site D: 2 half time

**On-site physician coverage**
- Site A: 3 for ½ day weekly
- Site B: any credentialed community physician
- Site C: 2 for 2 ½ days weekly
- Site D: 2 half time

**Physician practice outside CCRC**
- Site A: Yes
- Site B: Yes
- Site C: Yes
- Site D: No

**After hours coverage**
- Site A: Community practice
- Site B: Community practice
- Site C: Community practice
- Site D: Only CCRC clinicians

**Hospital proximity to CCRC**
- Site A: 2 miles
- Site B: 4 miles
- Site C: 2 miles
- Site D: 2 miles
## Medicare Utilization: Providers

**2011 Bynum et al**

### Table: Medicare Utilization - Providers

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
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<th>Site C</th>
<th>Site D</th>
<th>p value</th>
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</thead>
<tbody>
<tr>
<td><strong>PERSON YEARS</strong></td>
<td>403</td>
<td>416</td>
<td>952</td>
<td>623</td>
<td></td>
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<tr>
<td><strong>PROVIDER VISITS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Rate per person-year)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total visits</td>
<td>15.8</td>
<td>20.5</td>
<td>20.4</td>
<td>14.4</td>
<td>&lt;0.001</td>
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<tr>
<td>Primary care visits</td>
<td>6.4</td>
<td>7.5</td>
<td>8.8</td>
<td>4.6</td>
<td>&lt;0.001</td>
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<tr>
<td>Specialty care visits</td>
<td>6.2</td>
<td>6.3</td>
<td>8.5</td>
<td>3.0</td>
<td>&lt;0.001</td>
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<tr>
<td>Mid-level visits</td>
<td>1.6</td>
<td>4.7</td>
<td>1.2</td>
<td>4.1</td>
<td>&lt;0.001</td>
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<tr>
<td>Emergency dept visits</td>
<td>0.58</td>
<td>0.50</td>
<td>0.31</td>
<td>0.16</td>
<td>&lt;0.001</td>
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<tr>
<td><strong>CARE CONTINUITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Av # doctors seen</td>
<td>5.5</td>
<td>6.1</td>
<td>5.7</td>
<td>3.2</td>
<td>0.002</td>
</tr>
<tr>
<td>% who see &gt;10 drs</td>
<td>16.2%</td>
<td>17.1%</td>
<td>14.2%</td>
<td>5.9%</td>
<td>0.089</td>
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</table>
# Medicare Utilization: Hospital

2011 Bynum et al

<table>
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<tr>
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<th>Site D</th>
<th>p value</th>
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<tbody>
<tr>
<td><strong>PERSON YEARS</strong></td>
<td>1,926</td>
<td>2,303</td>
<td>5,563</td>
<td>2.904</td>
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<tr>
<td><em>(Rate per 100 person-years)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total admissions</td>
<td>30.0</td>
<td>28.9</td>
<td>25.4</td>
<td>15.0</td>
<td>&lt;0.001</td>
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<tr>
<td>Medical admissions</td>
<td>18.8</td>
<td>19.4</td>
<td>14.5</td>
<td>6.8</td>
<td>0.002</td>
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<tr>
<td>Surgical admissions</td>
<td>11.3</td>
<td>9.5</td>
<td>10.7</td>
<td>8.1</td>
<td>0.173</td>
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<td>Deaths in hospital (%)</td>
<td>14.4%</td>
<td>15.3%</td>
<td>14.2%</td>
<td>5.1%</td>
<td>0.004</td>
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</table>
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
Health-service and social-services expenditures for OECD countries (%GDP - 2005)

BMJ Qual Saf 2011;20:826e831.
Health-service and social-services expenditures for OECD countries (as Ratio – 2005)

[Bar chart showing the ratio of social to health service expenditures for various OECD countries, with the United States highlighted.]

BMJ Qual Saf 2011;20:826e831.
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

*No Integrator*

- Inappropriate
- Unreliable
- Unmanaged
- Wasteful “care”
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

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<th>Score</th>
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<td>7/1/2012</td>
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<tr>
<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>
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<td>2/28/2013</td>
<td>4</td>
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<td>3/2/2013</td>
<td>3</td>
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<td>6/1/2013</td>
<td>3</td>
</tr>
<tr>
<td>6/30/2013</td>
<td>4</td>
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The ideal score is 4.
BÄTTRE LIV FÖR DE MEST SJUKA ÄLDRE I JÖNKÖPINGS LÄN – KOMMUNER OCH LANDSTING TILLSAMMANS

MÄTTAVLA [dashboard]
Äldres läkemedelsanvändning i Jönköpings län

Jonkoping hospitals and municipalities
Pressure ulcer rate for People living in service homes
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.*
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 \( \geq 65 \) 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

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

Needs that cannot reasonably be met in the community

Attendance around the clock and 3 hours 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

▲ 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>Role</th>
<th>1000 NH Elders</th>
<th>4000 Community Elders</th>
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<tbody>
<tr>
<td>Direct care workers</td>
<td>500</td>
<td>1500 (½-3 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>
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”
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)
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>
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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>
<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/)
But how to motivate the changes … and sustain them?

△ 3rd year – convert 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
Customize services for frail elderly cohort
Generate good patient-centered care plans
Adapt medical care  Geriatricize
Include long-term services
Develop local layer of monitoring and management

Channel the fear and frustration into the will to change
How to Get Started #1: Promises

△ “What promises do your patients/clients most need to hear?”
“What keeps you from making those promises?”

△ May need focus group, surveys, or deliberate feedback to get guidance from patients/clients

△ Then being able to make the promises that matter usually requires making the system work across time and settings
How to Get Started #2: Feedback Loops

▲ Ensure that downstream experience gets to upstream providers in salient ways

▲ Simple notification (e.g., of death and its circumstances, of other major transitions) (example: death certificate follow-back)

▲ Highly salient notification – YouTube, letters from family

▲ Potential role of care plans and their evaluation
How to get started #3: Positive deviants
How to Get Started #3: Positive Deviants

▲ In almost every setting, someone is doing it just about right – a remarkable nursing home, a terrific hospice, a good geriatrics practice, a PACE program

▲ Find those “positive deviants” who are doing it right in the usual adverse incentives – and measure their performance and make their work visible – news stories count!

▲ Perhaps engineer competition to do as well

▲ Assure that the positive deviants do not fail and go away
How to Get Started #4: Relationships

- Get service providers together – over care transitions, budgets, measurements, or just lunch!
- Follow some patients together – do some process mapping – get the “aha” phenomenon going
- Be sure to meet in less visible settings – nursing homes, senior centers, etc.
- Use name tags, keep minutes, provide contact information
- Be able to deliver on at least some requests for data – e.g., a chart review, a death certificate follow-back
Managed care and ACOs are quickly seeing that frail elders are a major financial challenge.

Even conventional FFS Medicare hospitals are beginning to see that compensation<costs.

Some are beginning to be willing to write at-risk or service contracts for supplemental services.

The process of negotiation and multi-provider contracting can help bring the issues into focus and forge commitment to resolve them.
“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

▲ 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/)
A look into frailty

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