HARVARD MEDICAL SCHOOL

Coordinating Care for Vulnerable Elders

David C. Grabowski, PhD

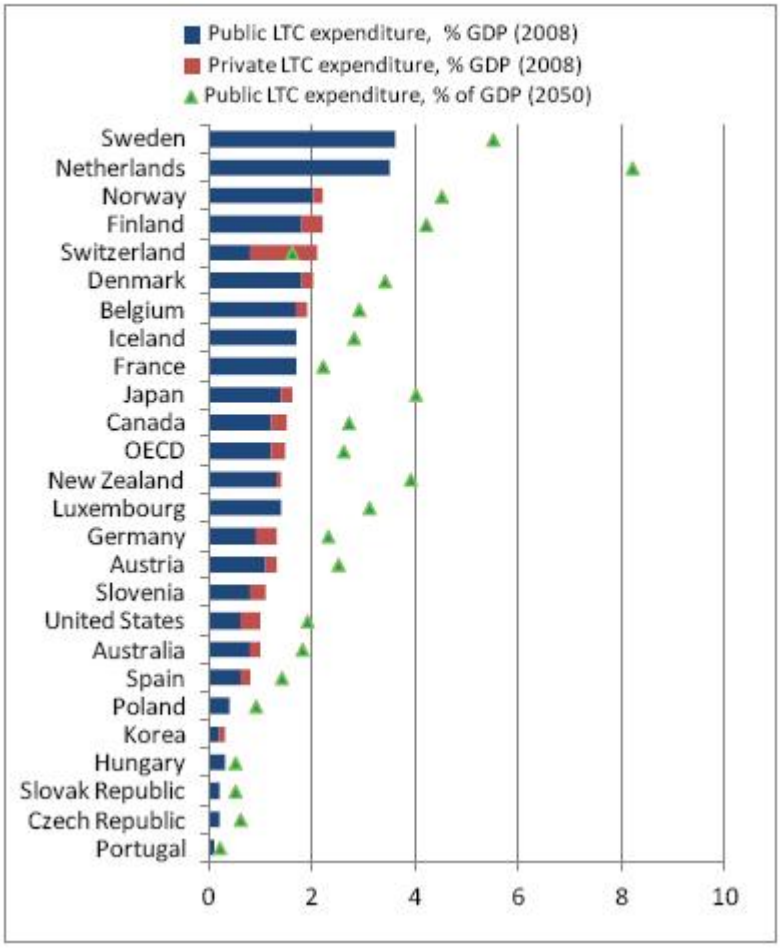
May 27, 2014

Talk Overview

- U.S. and Canada: different systems, common problems
- Dementia in the U.S.
- The Care Coordination Problem
- Possible Delivery and Payment Levers
- Innovative Program under U.S. Health Reform
- Challenges Moving Forward

International Perspective…

Figure 2. Public and private LTC expenditure in the OECD, 2008 and 2050



Both the U.S. and Canada have…

- Mix of public and private LTC funding
- Fragmented payment and delivery systems across LTC and other health care services

Dementia in the US

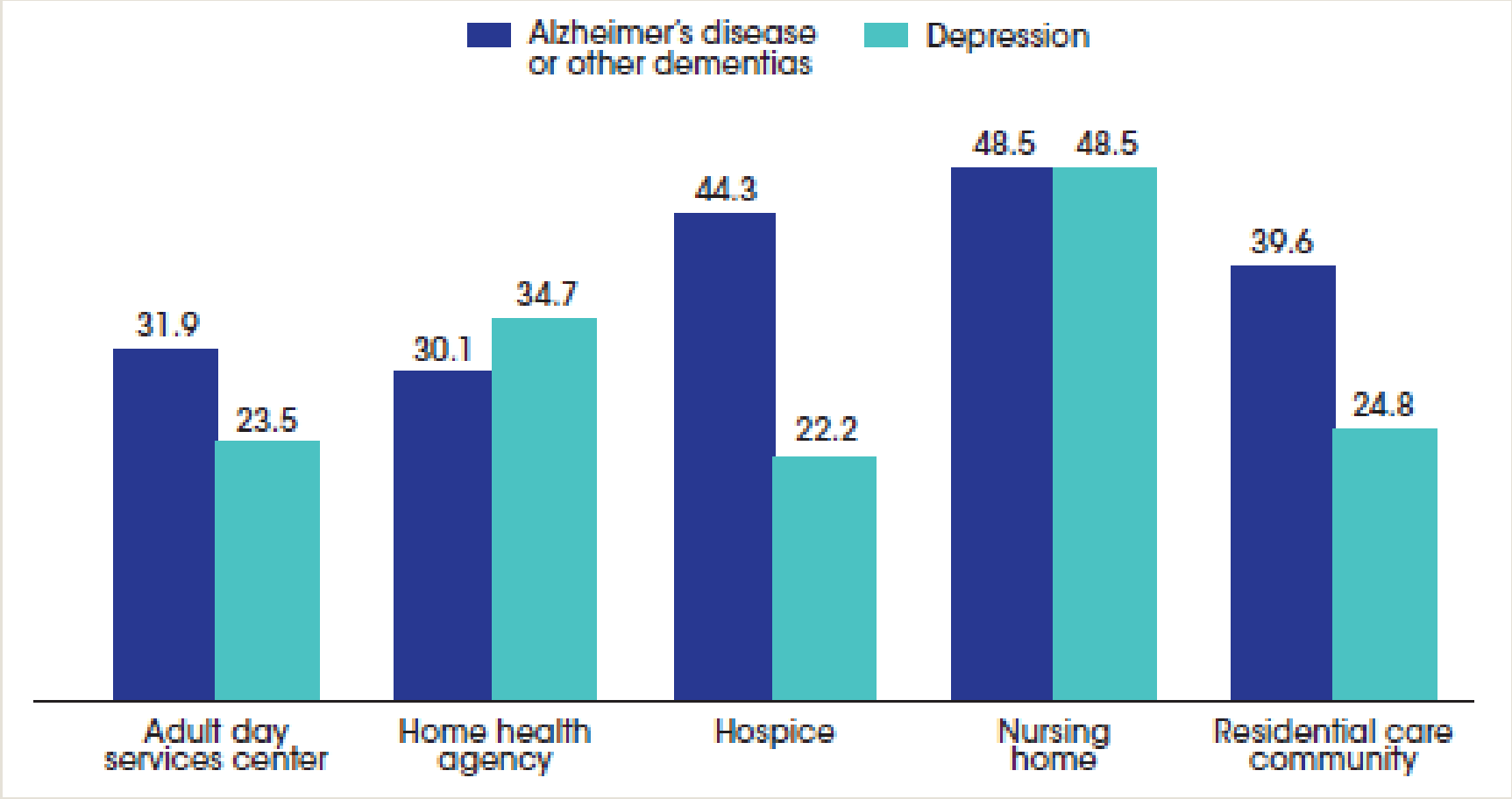
- 5.2 million Americans have dementia
  - Almost two-thirds are women
  - Nearly 500,000 individuals die each year because of dementia
- Dementia patients require a mix of health and LTC services

Health and LTC Utilization

Use	Incident Dementia (n=999)	No Dementia (n=2,674)
Any hospital stay	86.0%	51.2%
Total avg. hospital days	30.7	9.7
Any nursing home use	49.3%	13.9%
Total avg. NH days	158.1	15.5
Any home health care	65.2%	27.3%
Died	38.4%	21.2%

Callahan et al., JAGS 2012

Percent of Individuals with Dementia by Care Setting



Harris-Kojetin et al., NCHS, 2013

Dementia in U.S. (cont.)

- Most expensive condition in the U.S. with direct costs estimated at $214 billion in 2014
- Huge impact on informal (unpaid) caregivers
- Dementia care often of poor quality

Hospitalization of Dementia Patients

- Inappropriate hospitalization of dementia patients is prevalent

- Approximately 25% of NH residents with advanced dementia will have a hospital transfer in the last 6 months of life (Lamberg et al., 2005 JAGS)

Why so many avoidable hospitalizations?

HARVARD MEDICAL SCHOOL

A patient vignette…

“Ms. B”

90 years old; lives in a nursing home; dually eligible for Medicare and Medicaid

- Moderately advanced Alzheimer’s disease
- Congestive heart failure with severe left-ventricular dysfunction
- Chronic pain from degenerative joint disease

Ouslander and Berenson, NEJM 2011

Ms. B (cont.)

Under traditional payment and delivery model, Ms. B has:

- Three ID cards: Medicare, prescription drugs, and Medicaid
- Three different sets of benefits
- Multiple providers (NH, MDs, Therapists, hospital) who rarely communicate

Health/LTC decisions are uncoordinated and not made from person-centered perspective

Ms. B (cont.)

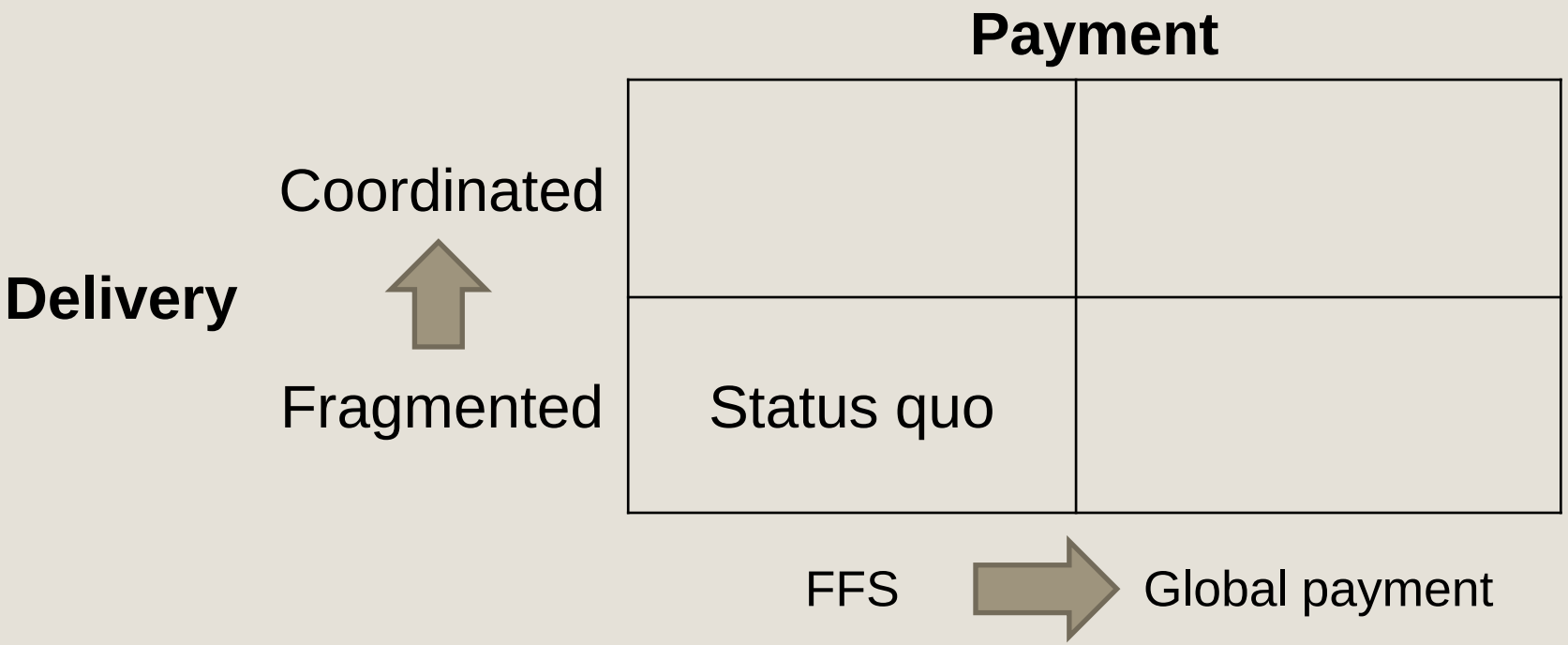
- Ms. B develops a nonproductive cough and a fever of 100.4°F
- Treatable in the NH, but in the typical scenario, she is going to the hospital
- Why?

Payment and Delivery Failures

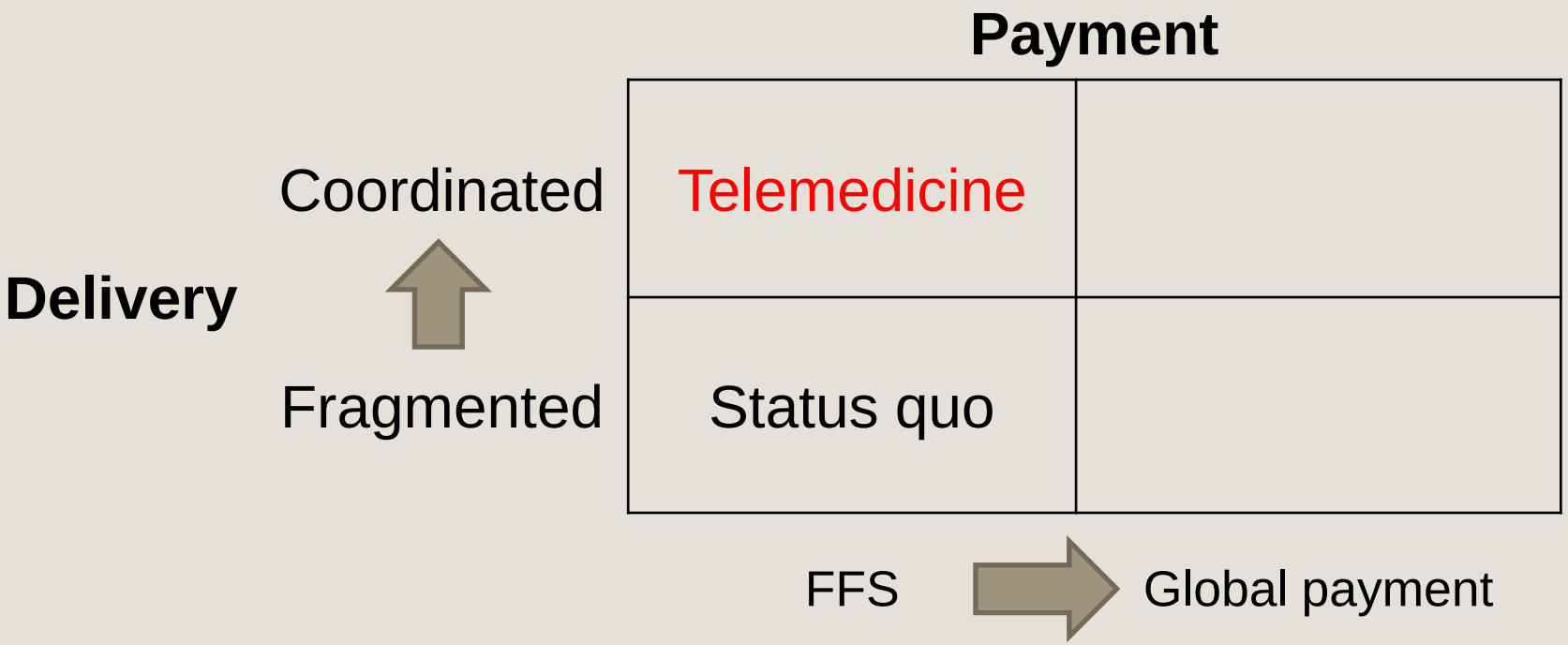
- ***Payment failure:*** Medicaid pays for NH care but does not share in any Medicare savings associated with reduced hospitalizations

- ***Delivery failure:*** NHs and other providers do not invest in infrastructure and expertize to treat residents safely in NH setting

Path to Reform



Path to Reform

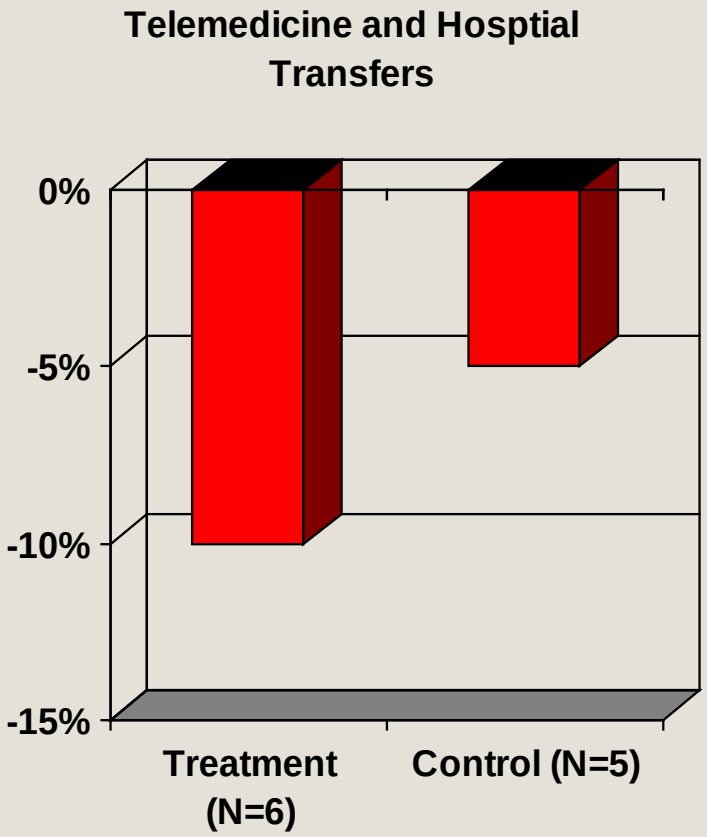


Delivery Reform: Nursing Home Telemedicine

- If a medical issue arises during evening/weekends (Ms. B), on-call physician can either come to the facility or recommend a transfer to the hospital
- All too often, the on-call physician sends the patient to the ER
- Telemedicine provides real-time physician consultations, which may prevent unnecessary hospital transfers

Delivery Reforms: Telemedicine (cont.)

- We conducted a pre/post randomized study of telemedicine in a Mass. nursing home chain
- Treatment nursing homes generated $100,000/NH annually in Medicare savings from prevented transfers
- Telemedicine service cost $30,000/NH annually



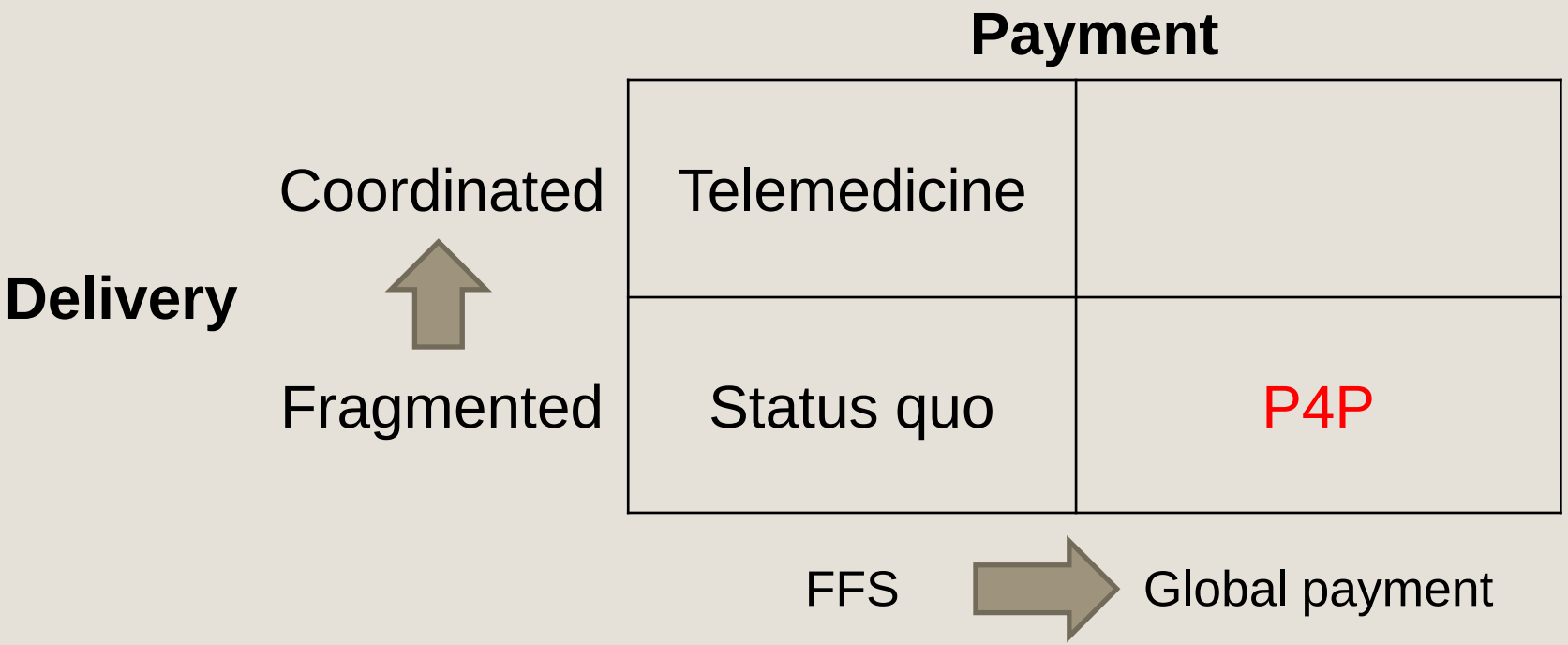
Grabowski & O'Malley, Health Affairs 2014

Lessons for Reform

- As long as nursing homes pay for interventions while Medicare enjoys savings, investment will be limited and unsustainable

- E.g., the NH chain in the telemedicine study never fully implemented intervention in control facilities due to Medicare SNF payment cuts

Path to Reform



Nursing Home Value-Based Purchasing Demonstration

- Voluntary CMS demonstration: July 1, 2009 through June 30, 2012
  - Arizona: 38 nursing homes
  - New York: 72 nursing homes
  - Wisconsin: 61 nursing homes
- Four performance domains: Staffing; survey inspections; quality measures; hospitalizations
- Top performing NHs receive reward payment, assuming cost savings (budget neutrality!)

Results

- Little pre-post change in performance across treatment and control NHs
- Mixed/negative results on savings

http://innovation.cms.gov/Files/reports/NursingHomeVBP_EvalReport.pdf

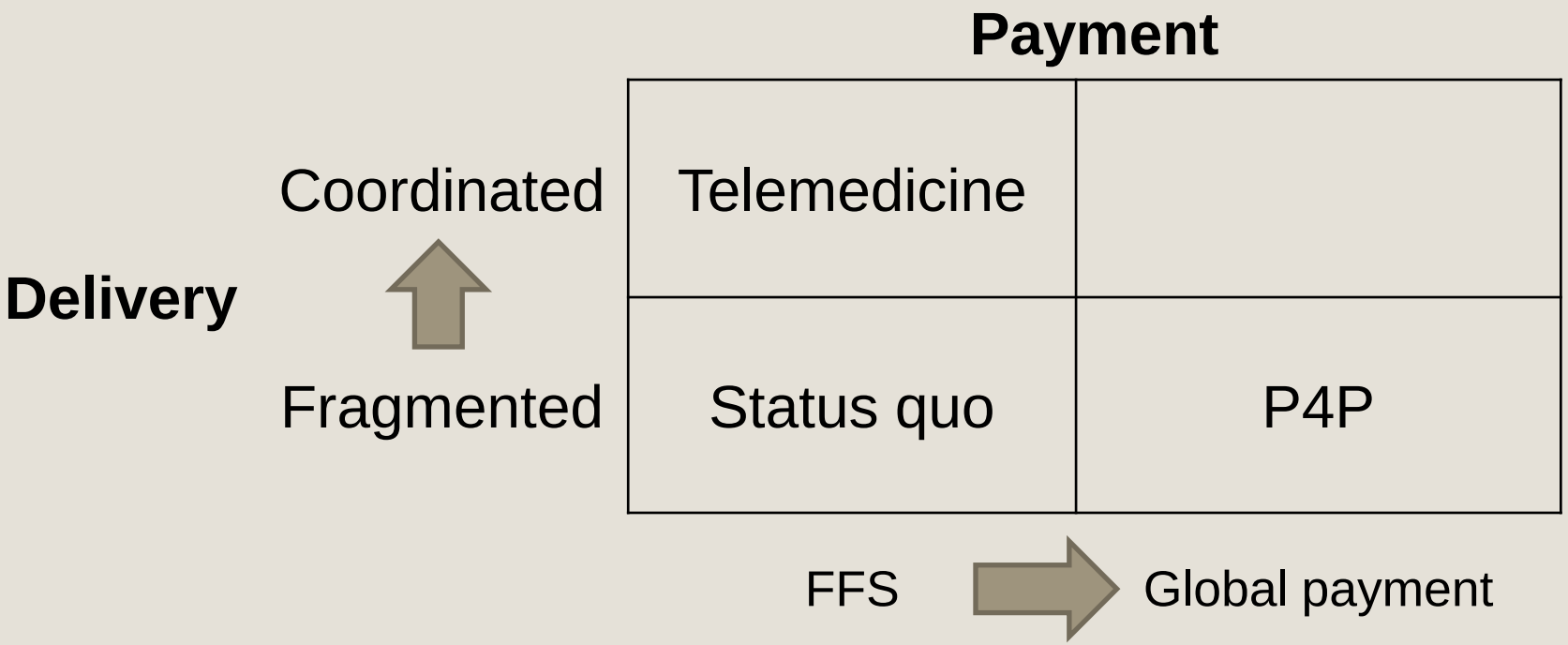
NHVBP: Medicare Savings?

	Arizona	New York	Wisconsin
Year 1	Yes	No	Yes
Year 2	No	No	Yes
Year 3	No	No	No

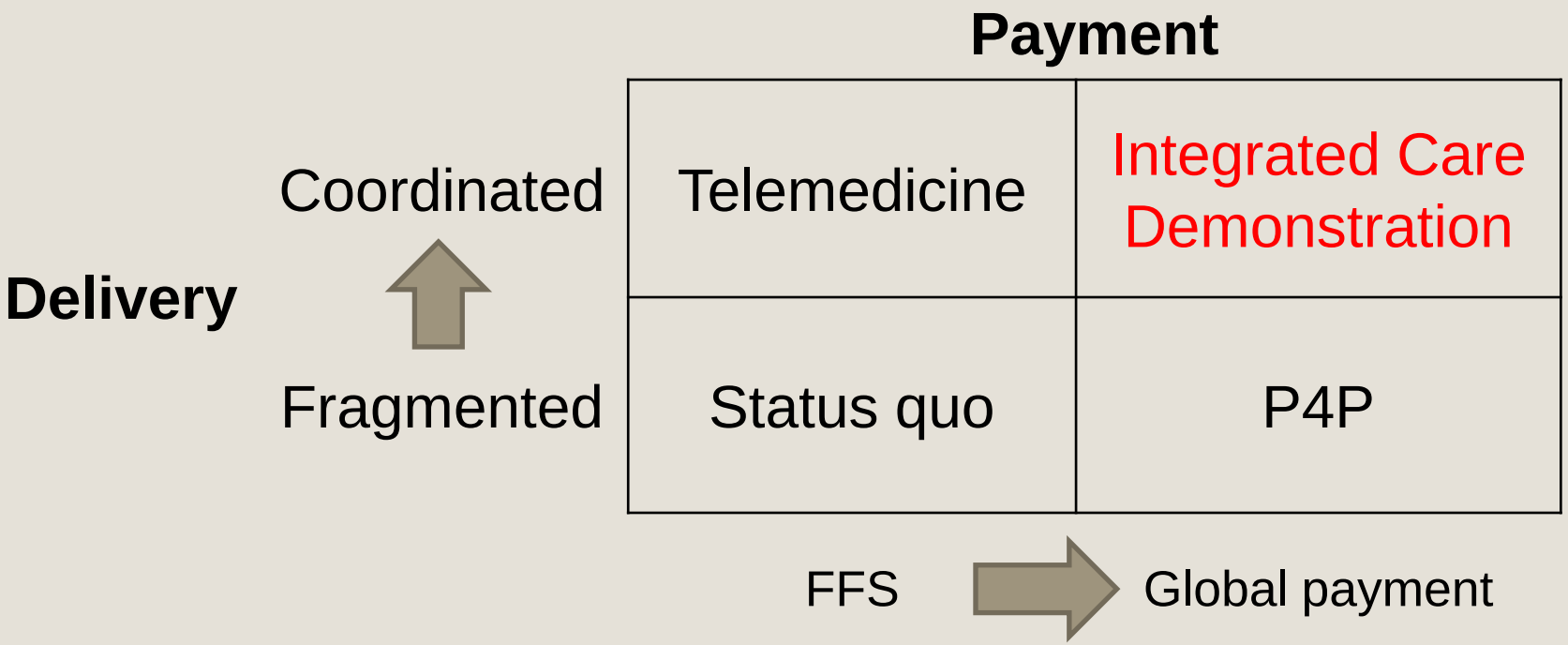
Lessons for Reform

- Our qualitative interviews suggested NHs did *not* make major investments towards preventing hospitalizations
- Broader economic literature suggests incentives without education not likely to succeed in the context of complicated tasks such as preventing hospitalizations
- Payment reform necessary but not sufficient!

Path to Reform



Path to Reform

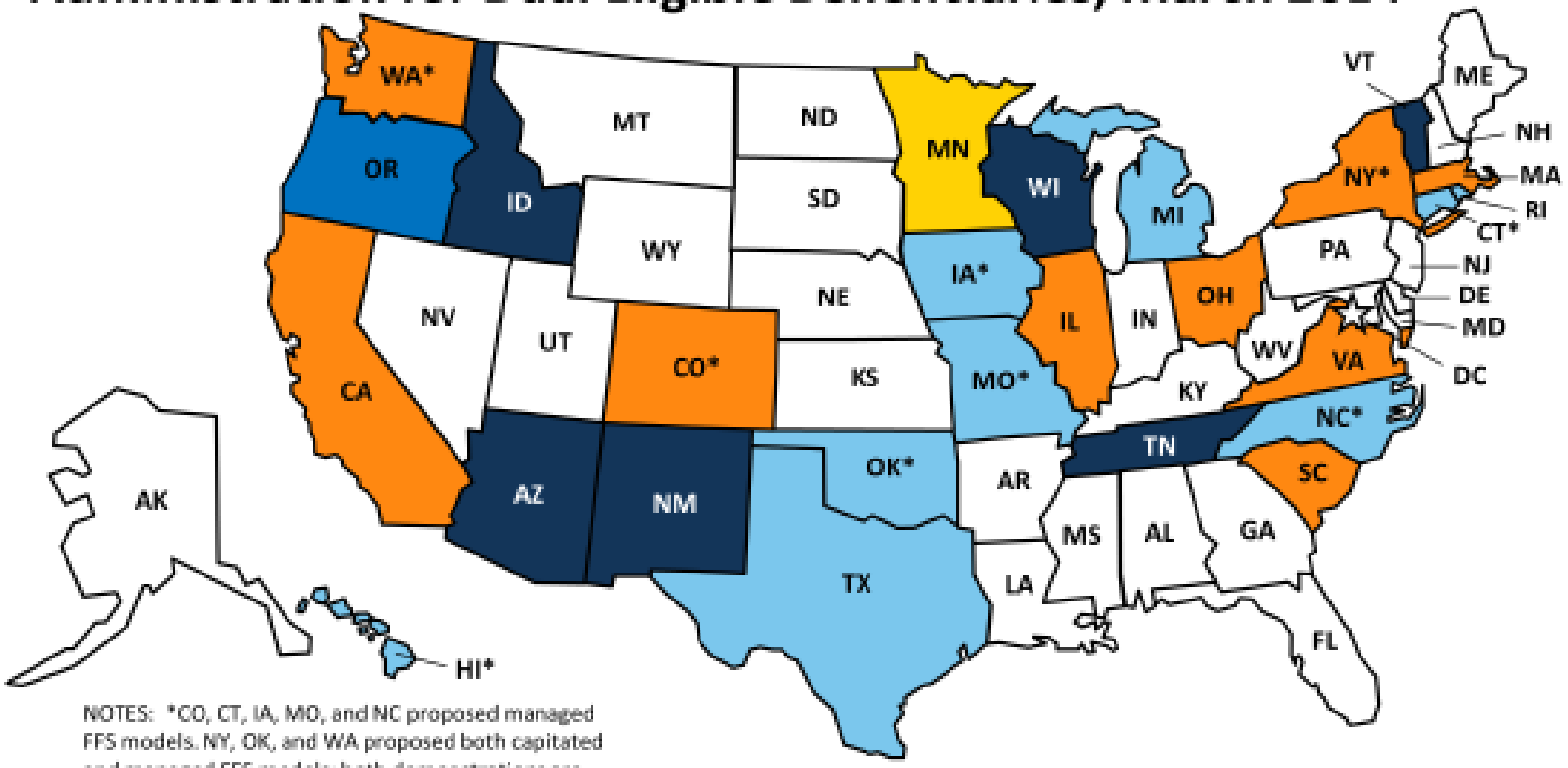


Integrated Care Demos

- Under ACA, 26 states received funding and approval to develop new models to coordinate care for dual eligibles

- Variation across states in proposed models but mix of payment and delivery level reforms

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, March 2014



NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; both demonstrations are approved in WA; NY withdrew its managed FFS proposal. All other states proposed capitated models.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html, and state websites.

- MOU signed with CMS to implement financial alignment demonstration (9 states)
- MOU signed with CMS to implement administrative alignment demonstration (1 state)
- Proposal pending with CMS (9 states plus NY's DD proposal)
- Proposal submitted, will not pursue financial alignment but may pursue administrative alignment (1 state)
- Proposal withdrawn (6 states)
- Not participating in demonstration (24 states and DC)

THE HENRY J. KAISER FAMILY FOUNDATION

Challenges for Reform Moving Forward

- Mandatory versus voluntary (opt in vs opt out)?
- Federal versus state approaches?
- Capitation versus FFS?

Health Quality and Utilization Outcomes of NH Residents With Advanced Dementia, by Health Insurance Status

Outcome	Fee for Service		Managed Care		Managed-Care Estimate (95% CI)[a]	
	No.	Mean (SD) or %	No.	Mean (SD) or %	Unadjusted	Adjusted[b]
Do-not-hospitalize orders[c]	852	50.9	703	63.7	1.9 (1.0 to 3.7)[d]	1.9 (1.1 to 3.4)[d]
Hospital transfers for acute illness[e,f]	331	15.7	229	3.8	0.3 (0.1 to 0.7)[d]	0.2 (0.1 to 0.5)[d]
Primary care visits in the nursing home in 90 d[g]	158	4.2 (5.0)	133	4.8 (2.6)	1.3 (1.1 to 1.6)[d]	1.3 (1.1 to 1.6)[d]
Physician visits	158	3.4 (4.7)	133	1.8 (1.5)	0.76 (0.6 to 0.9)[d]	0.7 (0.6 to 0.9)[d]
Nurse practitioner visits	158	0.8 (2.6)	133	3.0 (2.1)	3.0 (2.1 to 4.2)[d]	3.0 (2.2 to 4.1)[d]
Hospice treatment[g]	158	18.4	133	23.3	0.9 (0.5 to 1.5)	0.8 (0.4 to 1.5)
Family satisfaction with care (SWC-EOLD)[c,h]	638	31.6 (4.6)	538	32.3 (4.5)	1.0 (0.0 to 2.1)	0.9 (0.0 to 1.8)
Comfort in preceding 90 d (SM-EOLD)[c,i]	762	37.5 (7.6)	634	37.8 (7.5)	0.9 (−2.9 to 2.7)	0.1 (−1.7 to 1.8)
Comfort during last week of life (CAD-EOLD)[e,j]	81	34.9 (4.6)	66	34.0 (4.2)	−0.8 (−2.3 to 0.7)	−0.7 (−2.2 to 0.8)
Pain treatment[e]	147	10.2	114	16.7	1.8 (0.0 to 3.5)	1.6 (0.7 to 3.5)
Dyspnea treatment[e]	124	61.3	94	55.3	0.9 (0.5 to 1.8)	0.9 (0.4 to 2.0)
Pneumonia treatment[e]	127	100.0	79	100.0	...	...
Antimicrobial agent						
None	10	7.9	8	10.1	...	...
Oral	71	55.9	44	55.7	0.8 (0.3 to 2.1)	1.5 (0.4 to 4.9)
Intramuscular	16	12.6	17	21.5	1.3 (0.2 to 2.4)	2.9 (0.7 to 11.7)
Intravenous or hospitalization	30	23.6	10	12.7	0.4 (0.1 to 1.3)	0.6 (0.1 to 2.2)

Goldfeld, Grabowski et al., JAMA Intern Med 2013

Concluding Thoughts

Imagine Ms. B with an integrated model of care:

- One ID Card
- Comprehensive benefits: primary, acute, drugs, LTC
- Coordinated provider team; comprehensive individualized care plan
- Health care decisions based on Ms. B's needs/preferences