Focus On The Care Span For The Elderly And Disabled

Susan Dentzer
Editor-In-Chief

HealthAffairs
Health Affairs thanks for its support of the June 2012 issue of the journal as well as today’s briefing.
Barb Edwards
Director, Disabled and Elderly Health Programs
Group, Center for Medicare and Medicaid Services,
US Department of Health and Human Services
There is Little Experience and Limited Data To Support Policymaking On Integrated Care For Dual Eligibles

Marsha Gold
Senior Fellow
Mathematica Policy Research

With Gretchen Jacobson and Rachel Garfield
Kaiser Family Foundation
Integrating Care For Dual Eligibles Is Of Great Policy Interest

- Disproportionate impact on Medicare and Medicaid spending
- Many limitations in current delivery
- 26+ states proposing integrated models to CMS, with risk based managed care a key feature
- Paper provides a fresh integrated look at dual enrollment in managed care across both programs using public data sources.
Most Duals Now In Fee For Service Arrangements Despite Growth In Managed Care

Exhibit 1. Share of Dual Eligibles in Medicare Advantage and Medicaid Managed Care Plans, 2000-2008

- Share of Duals in Medicare Advantage Plans
- Share of Duals in Comprehensive Medicaid Managed Care Plans

Notes: Data exclude dual eligibles living in Puerto Rico and other territories. Medicaid managed care data include duals in commercial and Medicaid managed care organizations (comprehensive risk), health insuring organizations, and PACE plans. Information on dual enrollment in Medicaid comprehensive managed care plans was not available at the time of publication for years prior to 2004.

State Experience Highly Uneven

Exhibit 2. Share of Dual Eligibles Enrolled in Managed Care, by State, 2010

Note: National average was 12.0% enrolled in Medicare Dual-Special Needs Plan (DSNP) and 9.3% enrolled in comprehensive Medicaid managed care (MMC).

Source: Authors analysis of public Medicare and Medicaid data files from the Center for Medicare and Medicaid Services as cited in Gold, Jacobson, and Garfield, Health Affairs, 2012.
Large Gaps In Public Data For Understanding Managed Care Enrollment And Programs

• Best source (MCBS) not timely

• Public enrollment data don’t distinguish full versus partial duals

• Medicare Advantage data don’t show dual enrollment except for d-SNPs

• Medicaid data are not timely, don’t track overlapping enrollment, or show how programs interact to serve beneficiaries.
Implications

• Uneven experience with care delivery for duals should be factored into design and approval of new integration initiatives.

• Publicly available data need to be improved to support tracking and policy debate among stakeholders.

• Focus of integration initiatives will affect ability to learn and the benefits to people, programs, and public spending.
Users Of Medicaid Home And Community-Based Services Are Especially Vulnerable To Costly Avoidable Hospital Admissions

R. Tamara Konetzka
Associate Professor
University of Chicago

With Sarita L. Karon and D.E.B. Potter
Objectives

• Describe the population of users of Medicaid HCBS nationally
  – HCBS waiver enrollment
  – Use of waiver services
  – Use of state plan HCBS

• Assess the rate of potentially avoidable hospital admissions

• 2005 Medicaid and Medicare data
Potentially Avoidable Hospital Admissions

- Adapted from AHRQ Patient Safety Indicators
- Chronic Conditions Composite (diabetes, asthma, COPD, hypertension, angina, congestive heart failure)
- Acute Conditions Composite (bacterial pneumonia, urinary tract infection, dehydration)
- Overall Composite
Total 2.2 Million HCBS Users
Avoidable Hospitalization Rates
Main Findings

• HCBS population large and diverse
  – Need to consider state plan services
• High rates of potentially avoidable hospitalizations
• Two-thirds are dually eligible, with highest hospitalization rates
• Association with state policies intriguing but reasons unclear
AHRQ HCBS Project Team

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Social & Scientific Systems (SSS)
• Gary Moore
• Leif Karell

University of California-San Francisco (UCSF)
• Sei Lee, MD
Gradual Rebalancing Of Medicaid Long-term Services & Supports Saves Money & Serves More People

H. Stephen Kaye
Center for Personal Assistance Services
University of California San Francisco

Research funded by National Institute on Disability & Rehabilitation Research
How Does Shifting Toward HCBS Affect Overall LTSS Spending?

• Statistical model based on 15 years of spending data from 49 states + DC
• Includes spending on nursing homes & major HCBS programs (excl. I/DD)
• Answer: Rebalancing can save money, depending on how it’s done
  – More people served in rebalanced system
• Cutting HCBS increases total spending
Exhibit 2. Predicted trend in long-term services & supports expenditures during gradual rebalancing

Left scale:
- Predicted LTSS expenditure
- Prediction w/o rebalancing

Right scale:
- Waiver %
- Personal care services %
- Home health %

Per capita, inflation-adjusted expenditure ($)
Year

Percent
Exhibit 3. Predicted trend in long-term services & supports expenditures during rapid rebalancing favoring waivers

Per capita, inflation-adjusted expenditure ($)

Year

Left scale:
- Predicted LTSS expenditure
- Prediction w/o rebalancing

Right scale:
- Waiver %
- Personal care services %
- Home health %
Exhibit 4. Predicted trend in long-term services expenditures during rapid rebalancing favoring personal care services
Exhibit 5. Predicted trend in long-term services & supports expenditures during home and community-based services reduction

**Left scale:**
- Predicted LTSS expenditure
- Prediction w/o rebalancing

**Right scale:**
- Waiver %
- Personal Care Services %
- Home health %

Per capita, inflation-adjusted expenditure ($)

Year

0 1 2 3 4 5 6 7 8 9 10
Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-risk Patients

Randy Brown
Vice President, Mathematica Policy Research

With Debbie Peikes • Greg Peterson • Jennifer Schore • Carol Razafindrakoto, Mathematica Policy Research

HealthAffairs
I. Can Care Coordination Reduce Costs?

To generate enough savings in Medicare expenditures to cover the cost of care coordination, programs must:

1. Be targeted to the right people,
2. Provide proven interventions, and
3. Do so at low cost.
II. KEY FINDINGS – Only 2 Of 11 Programs Reduced Hospitalizations Overall, But 4 Did So For High-risk Enrollees

<table>
<thead>
<tr>
<th>Number of Enrollees (and % of all enrollees)</th>
<th>Control-Group Mean</th>
<th>Treatment-Control Difference</th>
<th>% Difference</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High- Risk Enrollees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Quality Partners</td>
<td>273 (17)</td>
<td>0.897</td>
<td>- 0.297</td>
<td>- 33.1</td>
</tr>
<tr>
<td>Hospice of the Valley</td>
<td>1,138 (71)</td>
<td>1.335</td>
<td>- 0.160</td>
<td>- 12.0</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>904 (79)</td>
<td>1.028</td>
<td>- 0.153</td>
<td>- 14.9</td>
</tr>
<tr>
<td>Washington University</td>
<td>1,975 (71)</td>
<td>1.643</td>
<td>- 0.132</td>
<td>- 8.1</td>
</tr>
<tr>
<td>Combined</td>
<td>4,290 (60)</td>
<td>1.376</td>
<td>- 0.147</td>
<td>- 10.7</td>
</tr>
</tbody>
</table>

Annualized Number of Hospital Admissions, 2002-2008
The High-Risk Group Definition

- Enrollees are high-risk if, at the time of enrollment, they:
  - Had (CAD, CHF or COPD) and 1+ hospitalization in prior year, OR
  - Had 2+ hospitalizations in prior 2 years (and one or more of 12 chronic conditions).

- High-risk definition has clinical face validity

- Easy to identify beneficiaries who meet definition via:
  - Claims
  - Patient self-report
  - Physician referrals or charts
III. The High-Risk Subgroup Accounts For A Disproportionate Share Of Medicare Costs

- 18 percent of Medicare FFS beneficiaries in 2003 met high-risk definition
- They are much more likely than other beneficiaries to be hospitalized and have multiple chronic conditions
- They account for disproportionate share of costs
  - 37 percent of Medicare FFS expenditures in the year after identification
  - 32 percent in the three years after identification
Care Coordinators:
1. Have frequent face-to-face contact with patients (~ 1/month)
2. Build strong rapport with patients’ physicians through face-to-face contact at hospital or office
3. Use behavior-change techniques to help patients increase adherence to medications and self-care
4. Know when patients are hospitalized and provide support for transition home
5. Act as a communications hub among providers and between patient and providers
6. Have reliable information about patients’ Rx and access to pharmacists or medical director

IV. What Distinguishes Successful Interventions?
Thank You

• We appreciate financial support from
  – Robert Wood Johnson Foundation’s Health Care Financing Organization and the Medicare Chronic Care Practice Research Network for follow-up work
  – The Centers for Medicare & Medicaid Services

• We appreciate invaluable assistance from
  – MCCD demonstration program directors and staff
  – Demonstration enrollees
  – Health Affairs and the SCAN Foundation

• For more information, please contact:
  – Randy Brown: rbrown@mathematica-mpr.com
  – Debbie Peikes: dpeikes@mathematica-mpr.com
  – Greg Peterson: gpeterson@mathematica-mpr.com
Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans

Patricia Neuman
Vice President and Director, Medicare Policy Project, Henry J. Kaiser Family Foundation
Rapid Reengineering Of Acute Medical Care For Medicare Beneficiaries: The Medicare Innovations Collaborative

Bruce Leff, MD
Professor of Medicine
Johns Hopkins University Schools of Medicine and Public Health

HealthAffairs
The “Portfolio Approach”

- Keep some patients with acute illness out of the hospital
  - Hospital at Home

- Move Inpatients Through the System Safely and Efficiently
  - Acute Care for Elder Unit (ACE), Hospital Elder Life Program (HELP), NICHE, Palliative Care

- Prevent Readmission
  - Care Transitions Programs
Medicare Innovations Collaborative

Hospitals/Health Systems Adopting Geriatric Portfolio Model

- Hospital at Home
- ACE
- NICHE
- Palliative Care
- HELP
- Care Transitions

Aurora Health (WI)

Carolina Health Sys – (NC)

Geisinger (PA)

Lehigh Valley Health – (PA)

Univ Hosp Case – (OH)

Crouse (NY)

Technical Assistance

Model Implementation

Identify Policy Enablers and Barriers

Sites Collaborate

Identify Best Practices
## Geriatric Portfolio Model Implementation

<table>
<thead>
<tr>
<th>Model Added</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model added de novo as part of the collaborative process</td>
<td></td>
<td></td>
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<tr>
<td>Model in use prior to the collaborative and not expanded</td>
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<tr>
<td>Model in use prior to the collaborative and expanded greatly as part of collaborative</td>
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<table>
<thead>
<tr>
<th>Aurora</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonprofit network, 15 hospitals, 150 clinics</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Carolinas</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd largest nonprofit public system in US, 30 Hospitals</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Crouse</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonprofit freestanding community teaching hosp</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Geisinger</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated health system, &gt; 55 community sites</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lehigh Valley</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonprofit academic community-based, 3 hospitals</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case</th>
<th>NICHE</th>
<th>Pall Care</th>
<th>Care Transit</th>
<th>ACE</th>
<th>HELP</th>
<th>HaH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban academic med center, 4 on-campus + community partner hospitals</td>
<td></td>
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</tbody>
</table>
Additional Key Lessons

• All health care is local; paramount influence on choice of models
• Technical assistance is key to model implementation
• Being part of a learning collaborative helped sites implement – developed and shared experiences and tools of adoption
• Models get adapted by adopter – fidelity issues
• Outcomes chosen from among 77: 30d readmit, LOS, pt satisfaction, # pts served, reduction in care costs
• Payment matters
• Policy implications – outcomes v systems of care that can affect multiple outcomes
Move Inpatients Through the System Safely and Efficiently

ACE/HELP NICHE Palliative Care

The Expanded “Portfolio Approach”
- Keep some patients with acute illness out of the hospital
- Hospital at Home

Care Management

Prevent Readmission
- Care Transitions Programs

Provide patient-centered, coordinated care
- Primary care - PCMH, GRACE, Guided Care, Medical house calls (Independence at Home), SNFs, ACOs
Acknowledgements

• The Atlantic Philanthropies
  – Stephen McConnell

• Medicare Innovations Collaborative Leadership Team
  – Albert Siu – Mount Sinai School of Medicine, James J Peters VA Medical Center
  – Lynn Spragens – Spragens and Associates
  – Barbara Morano - Mount Sinai School of Medicine
  – Jennifer Powell – Powell and Associates

• Aurora Health Care
  – Michael Malone

• Carolinas HealthCare System
  – Sindy McCrystle

• Crouse Hospital
  – Christy Bond

• Geisinger Health System
  – Terri Bickert

• Lehigh Valley Health Network
  – Catherine Glew

• University Hospitals Case Medical Center
  – Peter DeGolia

• Riverside Health System
  – Kyle Allen

• Model Experts
  – Liz Capazuti, Eric Colemen, Sharon Inouye, Sean Morrison, Diane Meier
Acute Care For Elders Units Produced Shorter Hospital Stays At Lower Cost While Maintaining Patients’ Functional Status

<table>
<thead>
<tr>
<th>Deborah E. Barnes, PhD, MPH (1,2)</th>
<th>Robert M. Palmer, MD, MPH (3)</th>
<th>Denise M. Kresevic, PhD, RN (4)</th>
<th>Richard H. Fortinsky, PhD (5)</th>
<th>Jerome Kowal, MD (6)</th>
<th>Mary-Margaret Chren, MD (1)</th>
<th>C. Seth Landefeld, MD (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) University of California, San Francisco; (2) San Francisco Veterans Affairs Medical Center; (3) Eastern Virginia Medical School, Norfolk, VA; (4) Louis Stokes Veteran Affairs Medical Center, Cleveland, OH; (5) University of Connecticut School of Medicine, Farmington, CT; (6) Case Western Reserve School of Medicine, Cleveland, OH.</td>
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</tbody>
</table>
Background

• Hospitalization often leads to disability in older patients

• Acute Care for Elders (ACE) units developed to help maintain function
  – Specialized hospital unit
  – Patient-centered care
  – Early discharge planning
  – Interdisciplinary team
ACE Shortened Hospital Stay Compared To Usual Care

Usual Care (7.3 days per patient)

ACE (6.7 days per patient)

P = .004
ACE Lowered Costs Compared to Usual Care

Usual Care ($10,451 per patient) vs. ACE ($9,477 per patient)

Cumulative Total Costs (2011 $) vs. Enrolled Patients

P < .001
### ACE Maintained Patients’ Function Without Increasing Readmissions

<table>
<thead>
<tr>
<th></th>
<th>ACE</th>
<th>Usual Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintained/Improved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Daily Activities</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>Instrumental Daily Activities</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>Mobility</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>Three-Month Readmission Rates</td>
<td>20%</td>
<td>19%</td>
</tr>
</tbody>
</table>

*No significant differences between groups*
Conclusions and Policy Implications

- ACE produces shorter hospital stays at lower cost while maintaining patient function
- Potential system-wide cost savings
- Strategies for expanding ACE
  - Incentives, dissemination programs, training
- New opportunities for ACE
  - Accountable care orgs, bundled payments
Acknowledgments

• Funding for this study was provided by the National Institutes of Health (R01 AG029233, R01 AG10418, K24 AR052667) and the S.D. Bechtel Jr. Foundation
How Changes In Washington University’s Medicare Coordinated Care Demonstration Pilot Ultimately Achieved Savings

Deborah N. Peikes
Mathematica Policy Research

I. Study Design

• Program was part of Medicare Coordinated Care Demonstration
  - Operated by Washington University from 8/02–8/08

• Measure impacts before and after program redesign
  - Natural experiment built onto a randomized trial
  - Before: Largely telephonic provision of care management (8/02–2/06, n=2,144)
  - After: More in-person contacts, stronger intervention (3/06–8/08, n=2,166)

• Examine effects on hospitalizations and costs, with and without care management fees
II. Enrollees Sicker Than Average Beneficiaries

<table>
<thead>
<tr>
<th>Patient Characteristics (% unless otherwise noted)</th>
<th>Washington University Enrollees</th>
<th>Medicare Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure</td>
<td>46</td>
<td>15</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>63</td>
<td>30</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Diabetes</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>Black, non Hispanic</td>
<td>38</td>
<td>9</td>
</tr>
<tr>
<td>&lt; 65 years old</td>
<td>27</td>
<td>14</td>
</tr>
<tr>
<td>Mean monthly Medicare costs in prior year</td>
<td>$2,498</td>
<td>$552</td>
</tr>
<tr>
<td>Mean number of annualized hospitalizations in prior year</td>
<td>1.8</td>
<td>0.3</td>
</tr>
</tbody>
</table>
### III. Key Changes In Intervention

- After redesign, model was more comprehensive, and in-person contact fostered relationships with patients and their providers.

<table>
<thead>
<tr>
<th>Category</th>
<th>Before Redesign</th>
<th>After Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts with patients and providers</td>
<td>Almost exclusively by phone for 80% of beneficiaries and their providers</td>
<td>Some in-person contacts to all beneficiaries and their providers</td>
</tr>
<tr>
<td>Patient assessments</td>
<td>Mostly by phone, overly standardized</td>
<td>More in depth and tailored; more accurate acuity determinations; monitoring to ensure nurses follow protocols</td>
</tr>
<tr>
<td>Care plans</td>
<td>Extensive guidelines but limited use</td>
<td>Streamlined, short, and more usable guidelines incorporated into care plans</td>
</tr>
<tr>
<td>Transitional care</td>
<td>Limited: Calls to patient in hospital and within 2 weeks of stay</td>
<td>Stronger: In-person visits with patient and providers in the hospital; follow-up call within 48 hours of discharge</td>
</tr>
<tr>
<td>Medication management</td>
<td>Encouraged patients to develop medication list</td>
<td>Care coordinators maintained and updated list; shared list with patients and treating physicians; resolved polypharmacy</td>
</tr>
</tbody>
</table>
IV. Large Impacts Only After Redesign; Driven by Higher-Risk Enrollees

Notes: ALL = All Enrollees. HR = Higher-Risk Enrollees.

Higher-risk enrollees met proprietary criteria and also had 2 or more hospitalizations in the 2 years before randomization. They were 55% of all enrollees.

** = p<0.05, * = p<0.1
V. Conclusions and Implications

- Care coordination was successful after a major redesign
- Results are driven by higher-risk enrollees
- Key is delivering the right services to the right people
- What are the right services?
  - Provide some in-person contact with both patients and providers
  - Visit hospitalized patients in person + call within 2 days of discharge
  - Create practical assessment and care planning tools, monitor use
  - Assess unmet needs thoroughly
  - Monitor medications aggressively
- Care management was not embedded in the primary care practice
- Promising model for ACOs, PCMHs, and other innovations
Thank You

• We appreciate financial support from
  – Robert Wood Johnson Foundation’s Health Care Financing Organization and the Medicare Chronic Care Practice Research Network for follow-up work
  – The Centers for Medicare & Medicaid Services

• We appreciate invaluable assistance from
  – The Washington University team of care managers, assistants, and operations director who worked diligently to achieve these outcomes and answer our questions
  – Demonstration enrollees
  – Health Affairs and the SCAN Foundation

• For more information, please contact:
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  – Greg Peterson: gpeterson@mathematica-mpr.com
  – John Lynch: jlynch@bjc.org
Presbyterian Healthcare Services: Hospital at Home

Melanie Van Amsterdam, MD
Lead Physician
Hospital at Home and House Calls Programs

Health Affairs
Presbyterian Healthcare Services (PHS)

**Hospitals**
- 8 hospitals in 7 communities
- Largest tertiary care facility; also community and critical access hospitals

**Health Plan**
- 400,000+ members throughout NM
  - Largest Salud (Medicaid) carrier
  - Largest Medicare carrier
  - 2nd largest Commercial carrier

**Medical Group**
- Multi-specialty group with over 700 providers
- Operates approximately 90 clinics in 44 facilities
Hospital At Home

• Established in partnership with Johns Hopkins

• Deploying physicians and nurses to the home to care for hospitalized patients
Hospital at Home Results – Triple Aim

Clinical Quality
• All are results equal or better than hospital:
  – Timely receipt of antibiotics in pneumonia patients is at or better than inpatient performance
  – Receipt of appropriate medications (ACE or ARB) in congestive heart failure is at or better than inpatient performance

Affordability
• Variable costs/stay are $1000-$2000 less than comparable inpatient stay – 19% lower

Exceptional Patient Experience
• Patient Satisfaction mean score = 90.7%
Video
Using Video Ethnography In Quality Improvement Efforts: Shaping Better Care Transitions At Kaiser Permanente

Esther (Estee) B. Neuwirth, PhD
Care Management Institute
Kaiser Permanente
Catalyzing Change For Quality Improvement

Video Ethnography

+ Patient & family, staff, physician engagement

+ Additional data

Results

Significant reduction in readmission rate in 6 months

Imagery: People in healthcare settings, indicating patient, family, staff, and physician engagement.
A New Tool – Video Ethnography

**Video Ethnography:** The rapid, applied use of ethnographic methods using video to capture observations and interviews, followed by analysis and then sharing of key findings for quality improvements across an organization or institution.
Inquiry To Action: A Four-Step Process

1. Plan
   Prepare project goals and questions

2. Collect
   Collect interviews and observations

3. Analyze
   Analyze and make sense

4. Share & Act

Link to our toolkit on video ethnography:
http://kpcmi.org/cmi-news/tool-kits
http://kpcmi.org/what-we-do/evaluationanalytics/returning-home-video/
Accelerating Organizational Performance

- What are we trying to accomplish?
- How will we know that change is an improvement?
- What change can we make that will result in improvement?

Model for improvement developed by Associates in Process Improvement © 1996
Power Of Observation And Shadowing

“What people say, what people do, and what they say they do are entirely different things.”

- Margaret Mead

Link to our toolkit on video ethnography
http://kpcmi.org/cmi-news/tool-kits
http://kpcmi.org/what-we-do/evaluationanalytics/returning-home-video/
Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns about Causes and Consequences

Zhanlian Feng
Brad Wright
Vincent Mor
Brown University

Support:
The Retirement Research Foundation (Grant 2011-066)
and
The National Institute on Aging (Grant P01AG027296)

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Phone: 401-863-3491

Panel 3:
Emerging Issues In Care and Coverage
National Press Club
Washington, DC
June 5, 2012

HealthAffairs
What Are Observation Stays?

- **Hospital-based outpatient services**
  - To treat, assess, and reassess while deciding whether or not to admit a patient
  - Must be ordered by a physician
  - Should not exceed 24 – 48 hours

- **Subject of controversy and lawsuits**

- **Purpose**—Using Medicare enrollment and claims data to describe trends in the prevalence and duration of observation stays among FFS beneficiaries

The Increasing Use of Observation Stays, 2007-2009

Prevalence

Duration

Ratio: Observation Stays to Inpatient Admissions

Sources: 100% Medicare Part A Inpatient and Outpatient Claims, 2007 - 2009
Rates of Observation Services Varied More than 7-fold Across States in 2009

Sources: Centers for Medicare and Medicaid Services, 100 percent Medicare enrollment file and Medicare (Part A) outpatient claims data, 2007–09. Note: Rates shown are monthly averages per state, weighted by the total number of at-risk beneficiaries per month in each state.
Comments

• Underlying causes unclear, but unlikely driven by major shifts in clinical severity
• Likely driven by Medicare policy changes, e.g.:
  – Condition Code 44 (2004-)
  – Medicare Recovery Audit Contractor program (2006-)
• Effects on beneficiaries not ascertained, but of concern:
  – Out-of-pocket costs (20% coinsurance)
  – Barriers to SNF care
  – Observation stays replacing re-admissions
• Ongoing work
  – Hospital & market characteristics
  – Beneficiary-level analysis of consequences
Long Term Care Insurance Demand

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With Jeffrey Brown and Gopi Shah Goda
Explanations For Lack Of Coverage

• Preferences and beliefs regarding
  – Risk, MC / MC coverage, state dependent utility, bequest motive

• Substitutes for Insurance
  – savings, home equity (i.e. able to self insure)

• Substitutes for care
  – Family

• Features of the private market
  – Lack of trust, counter-party risk, cost
Designed Survey To Examine Reasons

- Use ALP to interview ~1600 respondents 50+
- Asked if they agree/disagree with statements on a 5 point scale
- Statements related to above categories
  - e.g. It is a child’s obligation to help a parent with long term care needs
  - e.g. I am concerned that ins. company might not remain in business long enough to pay for my care
- Examine relationship between responses and LTC insurance in raw data and controlling for individual characteristics
Please indicate whether you agree or disagree with the following statements on a five-point scale.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare covers the extended use of long-term care for those over age 65</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medicaid covers the extended use of long-term care for those who qualify</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Most ordinary private health insurance policies cover extended stays in long-term care facilities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Results: Those Who ... Are More Likely To Have Ltc Ins Coverage

...prefer additional funds when sick
...think it’s important to leave a bequest
...lower expectation of living independently
...have resources or family to provide care
...prefer care from professionals than family
...believe insurance is appropriately priced
...are less concerned about solvency, premium increases, denial of claims...
### Exhibit 1

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rate of ownership if disagree/strongly disagree</th>
<th>Regression-adjusted change in ownership if agree/strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is important to leave an inheritance to my loved ones</td>
<td>17.2</td>
<td>9.4***</td>
</tr>
<tr>
<td>At some point in the future it is likely that I will no longer be able to live independently because of my health</td>
<td>14.2</td>
<td>12.0***</td>
</tr>
<tr>
<td>Even without long-term care insurance, I would have the means to pay for long-term care if I were to need it</td>
<td>23.1</td>
<td>−9.8***</td>
</tr>
<tr>
<td>Medicaid covers the extended use of long-term care for those over 65</td>
<td>22.3</td>
<td>2.5</td>
</tr>
<tr>
<td>Medicare covers the extended use of long-term care for those who qualify</td>
<td>18.6</td>
<td>4.4*</td>
</tr>
<tr>
<td>It is important to me that I not create a financial burden for my family if I need long-term care</td>
<td>17.5</td>
<td>5.1</td>
</tr>
<tr>
<td>If I need long-term care, a family member will be able to take care of me</td>
<td>27.3</td>
<td>−8.2***</td>
</tr>
<tr>
<td>I would prefer receiving care from a professional health aide or nurse rather than my spouse or another family member</td>
<td>15.7</td>
<td>9.1***</td>
</tr>
<tr>
<td>It is a child’s obligation to help a parent with long-term care needs</td>
<td>23.2</td>
<td>−3.2</td>
</tr>
<tr>
<td>I am concerned about my ability to afford the premiums for a long-term care insurance policy</td>
<td>46.1</td>
<td>−29.4***</td>
</tr>
<tr>
<td>Long-term care insurance policies are appropriately priced given the cost of the care they cover</td>
<td>14.0</td>
<td>24.0***</td>
</tr>
<tr>
<td>I am concerned that an insurance company may not remain in business long enough to pay for my care</td>
<td>33.9</td>
<td>−14.6***</td>
</tr>
<tr>
<td>I am concerned that once I own a long-term care insurance policy, an insurance company might raise my premiums</td>
<td>35.3</td>
<td>−14.1***</td>
</tr>
<tr>
<td>I am concerned that an insurance company might deny reasonable claims for long-term care</td>
<td>30.0</td>
<td>−8.0***</td>
</tr>
</tbody>
</table>

**SOURCE** Authors’ calculations. **NOTES** Regression-adjusted change represents the long-term care insurance ownership rate among respondents who agreed or strongly agreed with the statement minus the ownership rate among those who disagreed or strongly disagreed, controlling for age, sex, race or ethnicity, marital status, level of completed education, income, and wealth. Distribution of responses and raw ownership rates across responses are available in the online Technical Appendix (see Note 10 in text). *p < 0.10 ***p < 0.01
Conclusions

• Evidence in support of each hypothesis—limited demand not attributable to one factor

• Important caveat: Correlations not causality
  – Ex post rationalization
    • e.g. once purchase a policy report that expect firms to remain solvent, pay benefits
  – Reverse causality
    • e.g. In buying care learn about risk and benefits

• Selected sample

• Laid ground work for future research
Acknowledgments

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Half of Older Americans Seen In Emergency Department In Last Month Of Life; Most Admitted to Hospital, And Many Die There

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Purpose: How Common ED Visits In Last Month Of Life?

- Emergency Departments not designed to provide end-of-life care
- Most people prefer to die at home
- Pain, worsening symptoms, fear often precipitates ED visit
- Terminally ill patients acutely ill, symptomatic, plan uncertain, family in crisis
Methods

• Examined 4,158 people over age 65 who died in nationally representative Health and Retirement Study (mean age 83, 47% women)

• Linked Health and Retirement Study records to Medicare claims to examine use of emergency department and hospice
51% Of Older Adults Visited ED In Last Month Of Life
Other Findings

- 77% of those seen in emergency department admitted to hospital
- 68% of admitted died in hospital
- Emergency Department use in last month of life rare (10% vs. 56%) when enrolled in hospice one month before death
Policy Implications

• **Outpatient:**
  – Preparation for symptoms, discussion prognosis, goals of care discussions, documentation
  – Referral to hospice; early hospice may avoid high cost emergency department

• **Emergency Department**
  – Address attitudinal and structural barriers to high quality palliative care
Turbulence And Growth: Changes In The US Hospice Industry, 1999-2009

Jennifer Thompson
With Melissa D.A Carlson and Elizabeth H. Bradley

Health Affairs
Substantial Growth In US Hospice Industry

- **1983**: 40 Medicare-certified hospices
  - 10% were for-profit organizations
- **2010**: 3,555 Medicare-certified hospices
  - 53% were for-profit organizations
- Little discussion of how these changes occurred.
- Some evidence that hospice ownership type influences enrollment of patients, provision of patient care.
Changes in Operating Status, 1999-2009

- **1999**: 2,225 active Medicare-certified hospices
- **2009**:
  - 997 active, no ownership change
  - 792 active, ownership change
  - 350 otherwise terminated
  - 86 closed
Hospice Closures And New Hospices

Hospices active in 1999, Closed/terminated by 2009
- Nonprofit: 47.9%
- For-profit: 41.7%
- Government/Other: 10.3%

New hospices, 1999-2009
- Nonprofit: 12.6%
- For-profit: 80.2%
- Government/Other: 7.3%
In Unadjusted And Unadjusted Analysis Of Hospices Active In 1999:

- For-profit hospices were less likely to be active in 2009 than non-profit hospices.
- Hospices in Southern states were less likely to be active in 2009 than hospices in New England.
- Rural hospices were more likely to be active in 2009 than those in urban areas.
- Hospices affiliated with skilled nursing facilities were less likely to be active than freestanding hospices.
Acknowledgements

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Dignity-Driven Decision Making: Improving Care For People With Advanced Illness

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Senior Advisor, Nexera Inc
With Erin Westphal

HealthAffairs
What Is Dignity-Driven Decision Making?

• Distinguish from:
  – Patient-centered care
  – Patient-directed care
  – Person-centered care

• DDDM revolves around an ongoing relationship between patient and clinicians in which care decisions are made.
Characteristics Of Model Programs

- Dignity-Driven Decision Making *plus*
  - assured expedited access to providers
  - targeted populations
  - structured care processes – including care planning and case management
  - integration with community-based services
  - clinical services in the home
  - patient and family satisfaction as an outcome
Results Of DDDM-based Programs

• Reduced inpatient hospital use
• Reduced number of ED visits
• Perceived patient and family satisfaction
• Rigorous financial analyses just beginning
Expanding The Model

• Payment reform
  – Shared savings or other approaches
• Development of appropriate outcome/quality measures
• Clinician education, training, recruitment, and support
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