Shape of Things to Come: Advocacy and Reframing Senior Services

Jeffrey B. Klein, FACHE
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Context

“The trouble with the future is: It’s no longer what is used to be.”

~ Paul Valery
The Environment

How serious will the trajectory of demographic shifts and the effects of the health care delivery system change be on America’s most vulnerable populations?

Revolutionary Change

Prognosis:
- Social and health care delivery will be forced to function as a society in revolution including resource shifts, dramatic changes in order and an unsettled post-revolutionary era
- The entire American society will be drawn in as well as the participants
Perfect Storm

- Increasingly aged population
- 1 in 5 People - age 65+ by 2020
- 85+ Age Group - fastest growing segment of elder population

Perfect Storm

- Medicare Beneficiaries with Chronic Diseases
  - 2+ = 63%
  - 5+ = 21%
- 26% Functionally Impaired
- 95% Medicare $ Related to Chronic Conditions

Perfect Storm

- Greater functionality with chronic conditions
- Living longer, yet sicker
- Bottom Line: necessity of high quality coordinated care!
Perfect Storm

Work Force Dilemma
- Increased demand
- Constricted supply
- Falling unemployment
- Low compensation direct care workers 70% funded by government programs

Perfect Storm

We Have Medicalized Aging, and That Experiment Is Failing Us

Perfect Storm

The dichotomy:
We want safety for those we love and we want autonomy for ourselves.
1965: Three Important Programs Enacted

Medicare
Medicaid
Older Americans Act

“Every State and every community can now move toward a coordinated program of services and opportunities for our older citizens.”
~ President Lyndon B. Johnson, July 1965

Innovations in the Last Five Years in Health – Prevention

- Two-thirds of Medicare spending is for beneficiaries with five or more chronic conditions.
- The Evidence-based Prevention Program served more than 24,000 people last year in approximately 24 states.

The Last Five Years of Health & Long-term Care Reform: Branching Out in New Directions

- AoA innovation activities come out of the core programs in selected states, then are used to strengthen the core programs nationwide.
- Aging and Disability Resource Centers
- MIPPA & Medicare Part D enrollment
- Care coordination with the Department of Veterans Affairs (VA)
The Last Five Years of Health & Long-term Care Reform: Branching Out in New Directions

- Care Transition Activities
- Community Innovations for Aging in Place
- Medicare fraud detection – Senior Medicare Patrol
- Prevention and health promotion – Evidence-based programs
Recent Health Initiatives

- Evidenced-based programming
  - Chronic disease self-management
  - Caregiver support
- Community Living Program (AoA/CMS)
- Evidence-Based Care Transitions (AoA/CMS)
- Veteran’s Directed Home & Community Based Services Program (VD-HCBSP)

The Next Five Years: Health & Long-term Care Reform

- Serving an escalating senior population
- Enhancing care coordination/hospital discharge planning
- Reducing hospital readmission rates through ACA demo opportunities

The Next Five Years: Health & Long-term Care Reform

- Health care reform
  - Outreach
  - Long-term services and supports
  - Elder justice
- Caregiver service demand for paid/formal caregivers
- Expanding supportive services model to reach veterans of all ages
- Housing collaboration
Driving Delivery System Reform & Transformation

- Program & Policy Redesign
- Payment & Service Model Innovation
- Delivery System Reform & Transformation

2011-2019

2012-2019

2014-2019

Driving System Transformation

**UNMANAGED**
- Fee For Service
- Inpatient focus
- Poor access & quality
- Low reimbursement
- Little Oversight
- No organized networks
- Focus on paying claims
- Little Medical Management

**COORDINATED CARE**
- Accountable Care
- Organized care delivery
- Integrated Provider Networks
- Focus on Cost Avoidance & Quality Performance
- Medical home
- Care management

**PATIENT CENTERED**
- Integrated Health
- Patient Care Centered
- Personalized care
- Multiple integrated network & community resources
- Deployment of best practices
- Client & provider interaction
Affordable Care Act

INTENT

- Increase Access to Care
- Demonstrations:
  New payment & service delivery models

Affordable Care Act

Accountable Care Organizations
Community-Based Care Transitions
Medical Homes
Bundled Payments
30 Day Readmissions Penalties

PACE Services

Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible.
30 Day Readmissions

Reducing 30-Day readmissions
- Reductions in CMS payments
- Excess readmissions for high volume or high expenditure conditions & procedures
- Public report of readmission rates for Medicare participating hospitals on the internet

Final Rule Medicaid HCBS: A Complicating Factor

The Settings Rule

Final Rule CMS 2249-F and CMS 2296-F
Published in the Federal Register on January 16, 2014

Intent of the Final Rule

- To ensure that individuals receiving long-term services and supports through home and community-based service (HCBS) programs Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate
- To enhance the quality of HCBS and provide protections to participants
Settings that are **NOT** Home and Community-Based

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Hospital

Settings that are **PRESUMED NOT** to be Home and Community-Based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

The Shape of Things to Come: Convergence Health and Social Services

**Quo Vadis? Where Are You Going?**
The Shape of Things to Come: Convergence Health and Social Services

“ADAPT or DIE!”
~Andrew Grove, INTEL Chairman

Our changing environment dictates two rules:
1. Everything happens faster;
2. Anything that can be done, will be done; if not by you then by someone else.

A Complicated Landscape

Management Challenge

Challenge to offer the right services for the right person at the right time and in the right dosage, using the right instruments to measure progress toward goals.
Factors Driving New Models

- Ease of replication
- Readiness of organization
- Support of leadership and management
- Program costs, funding resources
- Assessment of barriers, ability to remedy

The Care Consortium: Integrated Delivery Model

Community Supports

Healthcare Services

Community Based Services
Context: A Question of Convergence

- Programs
- Services
- Strategy
- Mission
- Effectiveness

Hear the Music!

"And those who were seen dancing were thought to be insane by those who could not hear the music."

~ Friedrich Nietzsche

Too many of us aren't hearing the music yet....

The Care Consortium May Be Your Tune

The Shape of Things to Come: Convergence Health and Social Services

Think outside the box!

“Your imagination is a preview of coming attractions!”

~ Albert Einstein
The Care Consortium: Consortium Members

Community-based organizations
- Adult Day Health Care/Specialty Day Programs
- Home Delivered & Congregate Meals
- Housing
- Home Modification
- ADRCs
- Personal Care Agencies
- Legal Advocacy
- Transportation

The Care Consortium: Consortium Members

Healthcare
- Geriatric Assessment, Therapy,
- Chronic Disease Management Programs
- Alzheimer’s Disease & Other Special Population Service Providers
- Hospitals
- Physicians

The Care Consortium: Consortium Members

Research, Evaluation & Policy
- AAA and/or State Aging & Disability Services Division
- State Office of Consumer Health Assistance
- Universities
The Care Consortium: Consortium Members

Specialty Research & Training Centers

Education & Care Partner Support

- Alzheimer’s Association
- MS Society
- Heart Association
- Rosalynn Carter Center for Caregiving

The Care Consortium: Impact on Vulnerable Populations

- Empowers on-going long-term coordinated planning & decision-making
- Streamlines access to public & private services
- Links pathways to long-term services & supports
- Collaborates to secure grant funding for demonstration programs

The Care Consortium: Impact on Vulnerable Populations

- Offers evidence-based programs to support engagement of persons with needed services
- Provides a trusted resource for information & resources for consumers & professionals
- Is a “one-stop no wrong door” resource connecting services for aging and disabled persons in the community
Delivery Demonstrations: Future is Now – Case in Point

Central Texas Partnership
- Scott & White Healthcare
- Central Texas Department of Aging & Disability Services
- Central Texas Area Agency on Aging
  - ADRC: Single point of entry system

Scott & White Healthcare:
Accountable for the health, quality of life, and value of care in their community.

Areas of Caregiver Support
- Home Safety
- Using Social Support
- Managing stress
- Healthy Living
- Relating Memory Loss to Behaviors
- Legal & Medical Information
- Navigating services

Examples of services
- Respite, Adult Day Services
- Homemaker, Personal Care
- Medication Management
- Minor Repairs
- Occupational & Physical Therapy
- Assisted Transportation
- Home Delivered Meals
- Emergency Response

Results
Services Most Commonly Used

Change in Consumer Health Indicators

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<th>Baseline Mean (SD) or %</th>
<th>6-Month Mean (SD) or %</th>
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<td>8.5 (6.3)</td>
<td>7.4 (6.9)</td>
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<td>ER Visits</td>
<td>1.2 (1.4)</td>
<td>0.5 (0.9)</td>
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<td>Hospital Stays</td>
<td>1.2 (3.7)</td>
<td>0.4 (0.8)</td>
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<td>Physician Visits</td>
<td>6.8 (5.9)</td>
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Key Preliminary Findings

- Reaching older adults through community-healthcare partnerships is feasible
- Most avoided nursing home placements
- Caregiver burden was reduced
- Families were satisfied with services
- Consumer ER/hospital utilization was reduced

Mechanisms for Action

- Strategic Alliances & Partnerships
- Management (MSOs, ACOs & IPAs) Services Organizations
- Organizations contracted with, possibly formed by, multiple community based organizations to provide improved care coordination and successful delivery services – population health impact

Advocacy

Word origin: Medieval Latin advocatia, from advocare ‘summon.

Definition: Call to one's aid.
Advocacy

Who answers the Call?
Hillel’s Answer To Our Dilemma
“If I am not for myself, who is for me?”
- Self Advocacy
- Agency Leadership
- Board
- Clients

Advocacy

“When I am only for myself, what am I?”
- Making Common Cause Clients
- Senior Networks
- Disability Groups
- Vulnerable Populations

Advocacy

“If not now, when?”
The Future Is Now
Parting Thoughts

The change to a revolutionary mentality and the resultant dislocations will bring innovation, new ideas and fresh service delivery concepts.

Parting Thoughts

OPPORTUNITY IS NOWHERE

NO WHERE?
or

NOW HERE ?

Parting Thoughts

Organizations that blindly attempt to repair, adjust or tinker with everything may be in worse shape afterward, assuming that they survive at all, than those who adjust and come through the revolution changed and refocused.
Parting Thoughts

TRY NOT!
EITHER DO OR DO NOT

~Master Yoda

Parting Thoughts

“A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone’s lives.”

~ Atul Gawande
Being Mortal: Medicine and What Matters in the End

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Senior Services

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**Accountable Care Organizations**

- Medicare Shared Savings Program creates incentive for establishment of ACOs
- Networks of physicians & other providers
- Share savings resulting from the ACO's coordinated care
  - Reduced Medicare expenditures
  - Improved beneficiary health outcomes

**Community-based Care Transitions**

- Affordable Care Act calls for the establishment of community-based care transitions programs
- Provides funding hospitals and community based organizations
- Partnerships to improve care transitions services for high-risk Medicare beneficiaries

**Medical Homes**

Encouraging Medical Homes
- Interdisciplinary teams contracting with primary care physicians to provide supportive services to eligible patients:
  - Care coordination
  - Case management
  - Health promotion
  - Transitional care
  - Patient and family support
  - Referral to community services
Bundled Payments

Bundled payment pilots started 2013
Single Medicare payment to cover all services for an episode of care to be distributed among providers:
- Acute hospital services
- Physician services
- Post-acute community-based services
- Care coordination & transitional care services

Bundled Payments: PACE

- Old wine in new bottles – started 1970s
- Program of All-inclusive Care for the Elderly (PACE)
- Better for the well-being of seniors with chronic care needs and their families to be served in the community

Bundled Payments: PACE

- PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area.
- Built on a platform of adult day health care