

# Improving Acute Episodic Care of the Elderly

Dialogue on Aging and Healthcare in BC  
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# Options to Reduce Hospital Costs

- Pay on a PPS basis
- Encourage ACE units
- Create more PAC
- Reduce iatrogenic disease
- Develop intra-hospital case managers
- Deflect hospital admissions

# PPS Hospital Payment

- DRGs lowered LOS
- Saved money
  - Squeezing the balloon
- Shifted site of some services
  - Elective surgery
- No profound effect on quality
- Laid groundwork to reduce hospital labor
- Induced growth in PAC

# Acute Care for Elderly Units

- Shorter LOS
- Mixed effects on quality
- Not widely adopted

# Post-Acute Care

- Nursing homes
- Rehabilitation
- Home Health Care
- Substitutability
- Combinations
- Potential for bundled payment
  - PAC only
  - PAC and hospital
  - PAC and MD

# Reduce Iatrogenic Disease

- Desirable
  - Medical errors bad
- Feasible
  - Special staff
  - Protocols
  - IT
- Expensive
  - Delirium example

# Intra-Hospital Case Managers

- Improve efficiency
- Improve coordination, scheduling
- Oversee to avoid errors
- Costs offset by savings
- Marketed but never caught on

# Deflect Hospital Admissions

- Outpatient care
  - Elective surgery
  - Pre-op evaluations
- Transitional care
  - Direct admissions to TCUs
- NH care
  - Evercare experience
  - Managing NH residents in the NH
- Potential role of better primary care
  - PACE model

# Acute and Episodic Care?

- Most care is for chronic disease
- Most acute care is oriented around events vs. episodes
  - Payment is event- and activity based
  - Evaluations are too

# Premises

- Good chronic care makes a difference
  - Improves outcomes
  - Reduces utilization of hospitalization and ERs
- Geriatrics provides a strong model for good chronic care
- For those in LTC, medical care must be integrated into long-term care

# Goals of Chronic Disease Care

1. Manage the disease as well as possible to reduce the extent and frequency of exacerbations.
2. Prevent (or at least minimize) the transition from impairment to disability, and from disability to handicap.
3. Encourage patient to play an active role in managing his/her disease but avoid allowing the disease to become the dominant force in the person's life.

# More Goals

4. Provide care in a culturally sensitive manner.
5. Integrate medical care with other aspects of life without medicalizing those aspects.

# What is involved

- New definitions

- Prevention
- Patients' roles
- Time
- Place

- New approaches

- Systems
- Professional roles
- Expectations
- Information technology
- Management
- Integrating acute & LTC

# Definitions: Prevention

- Primary prevention
  - Simple (immunizations)
  - Complex (behavior change)
  - Avoid iatrogenic effects
- Tertiary prevention
  - Prevent exacerbations
  - Reduce expensive utilization
  - Prevent dysfunction

# Definitions: Patients' Roles

- **Shared responsibility**
  - **Monitoring**
    - Ongoing communication
    - Structured information
  - **Adherence**
    - Beliefs
    - Relationship
      - Communication
    - Active role in care
  - **Shared risk**
- **Shared decision making**
  - Need for better information

# Definitions: Time

- Chronic disease is omnipresent
  - Formal encounters are sporadic
  - Needs continuous monitoring
- Episode vs. Encounter
- Pay-off horizon
  - Up-front investment recovered over time
- Manage by change, not routine
  - Scheduling appointments
  - Length of appointments

# Definitions: Place

- Chronic care occurs across locations
- The same care can be provided in different settings

# New Approaches: Systems

- Requires more than re-education
  - BUT does require new skills
- Rethink roles
  - What should be done where, by whom?
  - Abandon linkage of site and service
- Rethink priorities
- Examine interfaces

# New Approaches: Professional Roles

- Consultants and GPs
- Downward delegation
  - non-physicians
  - non-professionals
- Primary care
  - simple cases
  - complex cases
- New teams
  - specialists & non-physicians

# New Approaches: Expectations

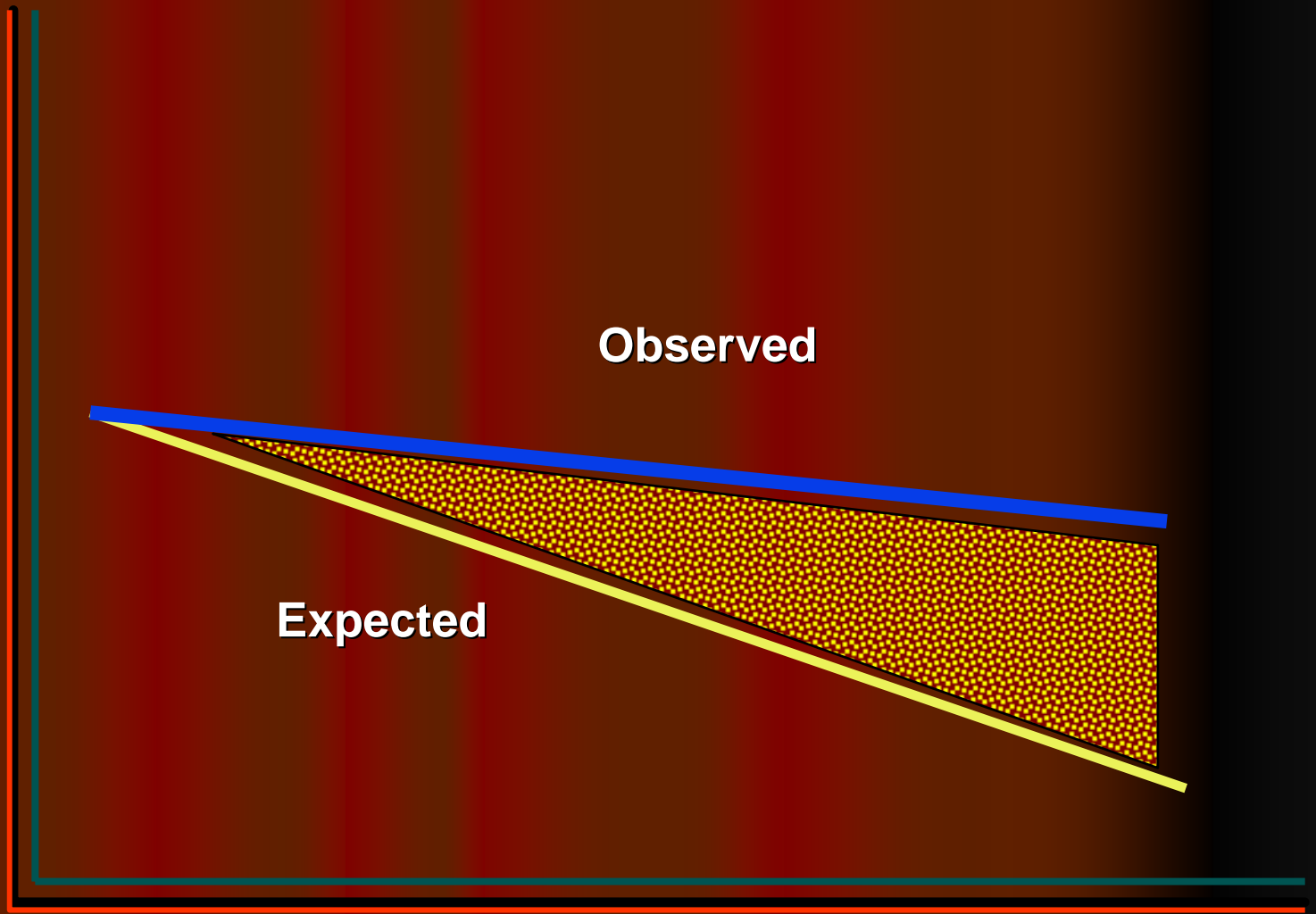
- Cure vs. Management
- Measuring success
  - actual vs. expected

**Outcome**

**Observed**

**Expected**

**Time**



# New Approaches: Information Technology

- Clinical problems may lie less with knowing what to do than what is happening
- Problems with too much as well as too little information.
- Need to focus provider & patient attention on salient data
- Web-based direct consumer education

# Information Technology

- Validated protocols

(EBM is great if E is strong. Consensus is different from wisdom)

- Professional
- Patient & family

- Structured information

- Clinical glidepaths

- Just in time information

- Information across sites of care

- Information = continuity

# Structured Data

- Computerized flow sheets
  - Data displays combining status and treatment
- Automated patient histories
- Reminders
- Use structured data bases to draw attention to neglected areas
  - QoL items
- Universal drug information
  - Structured ordering

# New Approaches: Management

- Disease management
  - Better if integrated with primary care than independent
  - Targeted patient self-care
  - Education
  - Motivation
  - Attitudinal change
- Doctor-patient partnerships
  - Information based
  - Patient empowering

# New Approaches: Integrating Acute & LTC

- Shared goals
- Outcomes accountability
  - Observed vs. expected
- Role of case management
  - Proactive primary care
- Need to address primary care
  - Active role for geriatric consultants in LTC
  - NPs
  - Better trained GPs

# Strategies for Improving Chronic Disease Care

- Interdisciplinary team care
- Group care
- Direct consumer education
  - Web-based info re various conditions
  - On-line info that triggers individually tailored messages to consumers

# Strategies for Improving Chronic Disease Care (cont'd)

- Information systems
  - Clinical tracking systems
    - Early warning detection
    - The new DEW line
  - Computerized physician order entry
  - Mobile computing
- Restructured health delivery roles
  - Add nurses & others to fill in for MD gaps
  - Substitute NPs for primary care MDs

# US Managed Care Experience

- Managed care seems to offer the ideal setting for chronic care principles, BUT it did not work in US context
  - Initial incentives favored case mix selection
  - Providing better care did not create a competitive advantage
  - Danger of attracting sicker clientele
  - Hard to create a case mix correction for the full care spectrum
  - Americans do not accept restrictions well
  - Publicly traded for-profit MCOs needed to show quarterly earnings

# Lessons from US Managed Care

- Difference between case management and disease management
  - Merge two and link tightly to primary care
- Need to think in terms of long-term investments across areas
  - Spending in one area care yield savings in another
    - Intra-medical (Evercare model)
    - Medical v. social
  - Less incentive to save someone else's money

# Lessons from US Managed Care 2

- Using less expensive alternatives
  - PAC
- Use central expertise to develop strategies
- Allow referral of complex cases to experts
- Information infrastructure
- Measure success across larger units of care
  - Look for offsetting effects

# Lessons from US Managed Care 3

- Changing the payment system alone will not achieve the ends sought
  - Need to change the way care is delivered (Dual demos)
- Align incentives and goals
- Incentives for clinicians and care systems are necessary but not sufficient
  - Need to address infrastructure
- NPs can play a useful primary care role

# Hospital Care Advice

- Assumptions about the role of hospitals need to be challenged
- Multiple strategies available
  - Some obviate others
    - DRGs shift burden to hospital management
  - Each will have repercussions
    - DRGs promote PAC
  - Want to avoid paying twice

# Bigger Picture Advice

- Action is urgent
- Enough is known to make a start
- Start modestly and learn from early experience
  - Build on small successes
- Need to invest in both infrastructure and people
  - IT is crucial
- Need to tolerate front-end investment strategy
  - Realistic time frame
- Need to assure that investment does actually pay off

# Improving Consumer Decisions

- Defining real choices
  - Clarifying goals
  - Identifying options
- Structuring the process
  - Separating salient questions at each stage
  - Identifying relevant parameters
- Providing good information on risks and benefits
  - Relevant to decision maker
  - Interactive format
- Mediating the psychic stress
- Achieving family consensus

# Information Options

- Online self-directed
- Structure for case manager
- Shared decision-making

# Example: LTC

- Two basic elements
  1. What modality of care is best
  2. Which providers of that modality are best
- Different criteria for each step

# Choosing LTC

## Modality Criteria

- Effectiveness based on most salient outcomes
- Cost/coverage
- Imposed limitations/losses/restrictions

## Vendor Criteria

- Access
- Cost
- Ambiance
- Quality

# Minnesota Model

- **Stage 1**
  - **Assessment-→profile**
    - Characteristics
    - Preferences
  - **Matched to scenarios rated by national expert panel**
  - **Recommendations for modalities**
- **Stage 2**
  - **Select most salient criteria from fixed list**
  - **Matching by priority weights**
  - **Ranked list**
  - **Details on each provider**