

Geriatrics, Clinical Redesign and Healthcare Reform

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Affiliations and Disclosures

- No disclosures
- Until 9/1/2012: University of Michigan
 - Assistant Dean for Clinical Affairs
 - Associate Director of Faculty Group Practice
 - Medical Director Pioneer ACO
 - Medical Director, PGP Medicare Demonstration (2005-2010)
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Presentation Goals

- General overview: delivery system reform and geriatric care principles
- Case Study: UM's experience with clinical redesign
- Geriatrics and Academic Healthcare Systems
- Quality

Affordable Care Act

- Insurance Reform
 - Expand insurance coverage
 - Reform insurance practices
 - Controversial, success unclear
- Delivery System Reform
 - Bi-partisan
 - Not going away
- Cost control, entitlement cuts ?

Delivery System Reform (all payers, both parties)

Payment Reforms
“Outcomes-based
payment”



Value-based
PBPM
Shared savings

Degrees of:
Performance risk
Insurance risk

Capitation



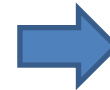
Delivery System
Redesign:
Clinical Integration



PCMH
primary care
specialty care

Care coordination
structures
Post acute and home
based models
Bundles

ACOs



Patient centered care
Population management
Efficiency



Triple Aim
IOM quality

“Bend the curve”

Downsize

Changing care delivery to improve Value

Concepts/Names

- Managed Care
- Bundles
- Medical Home
- Organized System of Care
- Clinical Integration
- Accountable Care Organization

Components

- Financial Model
- Redesign Structure
- Provider Group Structure
- Quality Evaluation
- Clinical Model

Complex patients experience fragmented care



Geriatric Care Models and Concepts Inform Delivery System Redesign

- Clinical leadership – governance and champions
- Models of care
 - Transitional care
 - BOOST
 - Acute care of the elderly (ACE) units
 - Geriatrics patient safety principles
 - Comprehensive assessment
 - Care coordination
 - Multidisciplinary teams
 - Medical home/ Intensive primary care
 - GRACE

Geriatric Care Models and Concepts Inform Delivery System Redesign

- Post-acute care
- PACE
- Home and community based services
- Palliative Care
- Quality
 - Complex patients
 - Extrapolation of evidence
 - Geriatric conditions
 - Function
 - Patient reported outcomes

Geriatric Care Models and Concepts Inform Delivery System Redesign

- Efficiency
 - Readmissions
 - Appropriate care
 - Medication Reconciliation
 - Patient preferences
 - High cost and complex patients
 - Frail elders
 - Multiple chronic conditions
 - Dual eligibles
 - Advanced Disease

Example: Building an Accountable Care Organization with Geriatric Models of Care

The Physician Group
Practice Medicare
Demonstration at the
University of Michigan

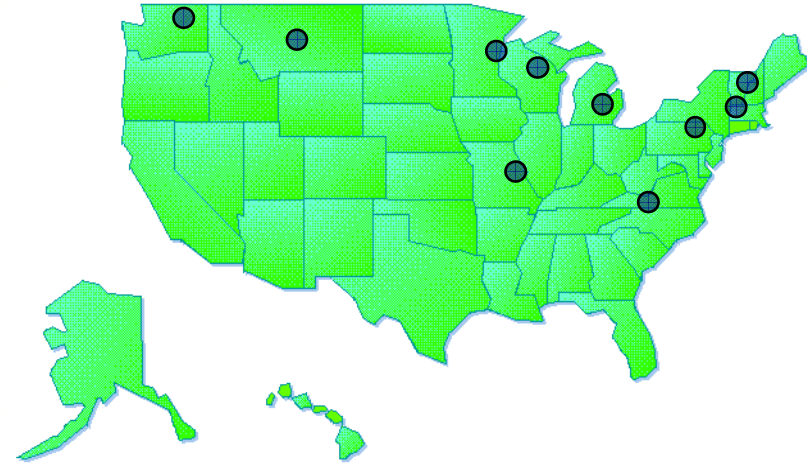


Physician Group Practice (PGP) Medicare Demonstration

- Prototype for ACO; Aimed at finding out whether care coordinating interventions can generate overall Medicare savings for a population of Medicare patients.
- The University of Michigan participated in the PGP Demonstration along with 9 other large physician groups from 2005-2010, and was successful
- Shared savings model; If a group practice saved money, it got some money back.
- Besides saving money, group practices had to achieve quality metrics

PGP Participants

- Geisinger Clinic (PA)
- Marshfield Clinic (WI)
- The Everett Clinic (WA)
- Forsyth Medical Group (NC)
- St John's Health System (MO)
- Deaconess Billings Clinic (MT)
- The University of Michigan (MI)
- Dartmouth-Hitchcock Clinic (NH)
- Park Nicollet Health Services (MN)
- Integrated Resources for Middlesex (CN)



The ten participating physician had:

- 5,000 physicians and
- 224,000 Medicare fee-for-service beneficiaries.

UM's Results from Participation

- ▶ Successful each performance year in earning shared savings and achieving quality metrics
 - ▶ One of 2 groups that achieved savings all 5 years
- ▶ Saved the Medicare Program over \$22 (\$46) million
- ▶ Earned shared savings of over \$17.6 million
- ▶ Received an additional ~\$3 million for PQRI participation
- ▶ Received national recognition as a leader in health care value and a pioneer in developing ACOs

Accountable Care Organizations (ACOs): One of the Key Ideas in Healthcare Reform

- ACA includes provisions for creating “Accountable Care Organizations” for Medicare beneficiaries
- ACOs are organized provider groups, including physicians, hospitals, and post-acute providers, responsible for health care of a population
- Goal: Deliver care in a less costly and more coordinated, efficient and patient-centered manner
- Centers for Medicare & Medicaid Services (CMS) is leading this but commercial insurance is very involved

Important components of an ACO

- **Financial model** – growth vs. cost, upside/downside risk, shared savings, capitation, risk corridor and size
- **ACO Design**- comparison group, patient attribution, case mix adjustment
- **Provider group structure** – Governance, integration, infrastructure (especially EMR, registries, data analytic capability)
- **Quality/Efficiency evaluation methodology** - how good are they, what is the burden

Components needed for success

- Clinical models of care
- Physician engagement

Key Clinical Interventions

Overall strategy: Decrease preventable admissions/readmissions, manage chronic conditions, and coordinate care of complex and costly patients

- Transitional care interventions
 - Call-Back Program for patients discharged from hospital and ED
 - Geriatric acute care consults, delirium prevention program, BOOST
 - Transitional care clinics in Geriatrics and Cardiology
 - Sub-acute nursing home program
 - Home care, home visits
- Care coordination interventions for high risk/high cost patients
 - Complex care coordination for frail elders, dual eligible Medicare
 - Disease management program for heart failure and diabetes
 - Palliative care consult service and hospice program for end of life care
- Year 5 – Patient centered Medical Home (PCMH) implemented

Geriatrics and Academic Healthcare Systems

Clinical Redesign Issues for an Academic Medical Center

CON's

- AMC's experience adverse patient selection
- AMC's may have unstable population for management
- AMC's may have an insufficient primary care foundation
- AMC's have other missions (research, teaching)
- Referral business may be different from ACO business

PRO's

- ▶ AMC's may be best suited to care for high cost/high risk patients (UMHS was most successful this group)
- ▶ Academic systems have Geriatrics and other specialties used to complex patients
- ▶ Academic physicians may be more attuned to "appropriate" care
- ▶ In FFS world, AMC's may be relatively integrated

Target Minus Assigned Beneficiaries Expenditures Per Person Year by Subgroup, Performance Year 2

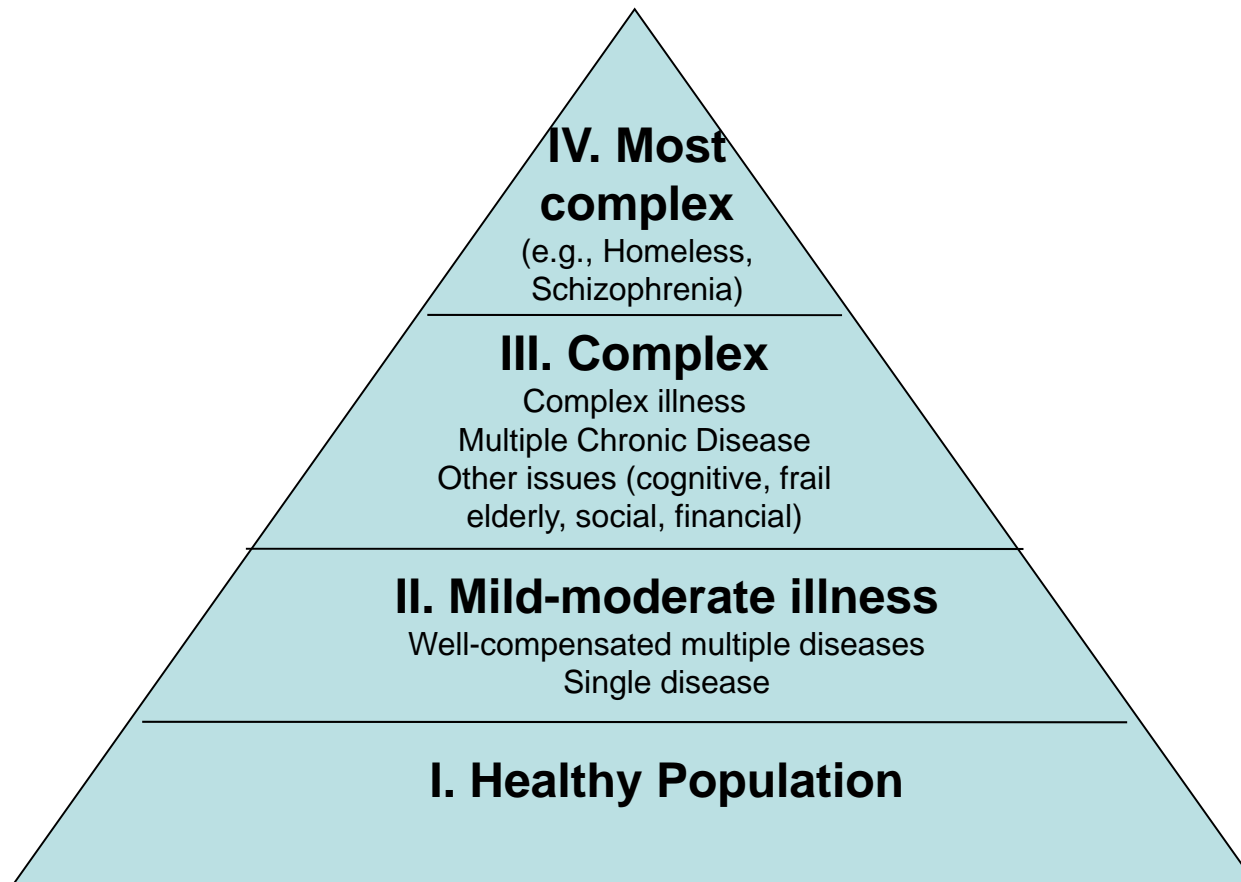
Subgroup	Assigned Beneficiary Prevalence (%)	Average of 10 Group Practices		Average of 4 Groups Sharing PY2 Savings		Average of 6 Groups Not Sharing PY2 Savings		University of Michigan	
		Difference (\$)	P-Value	Difference (\$)	P-Value	Difference (\$)	P-Value	Difference (\$)	P-Value
All Assigned Beneficiaries	100.0%	120	0.00	334	0.00	-23	0.65	335	0.06
Congestive Heart Failure	13.9%	103	0.60	378	0.27	-81	0.71	755	0.28
Any of the 70 Risk Adjusted Diagnoses	72.3%	161	0.01	459	0.00	-38	0.62	452	0.05
Decedents	4.3%	938	0.14	1698	0.13	431	0.58	4,082	0.04
Risk Score in upper 10%	16.0%	413	0.17	1459	0.00	-285	0.45	1,654	0.04
Risk Score in upper 25	33.5%	231	0.13	777	0.00	-133	0.44	923	0.04

Growth rate in Medicare spending from Base Year (2004) to Year 5 (2010)

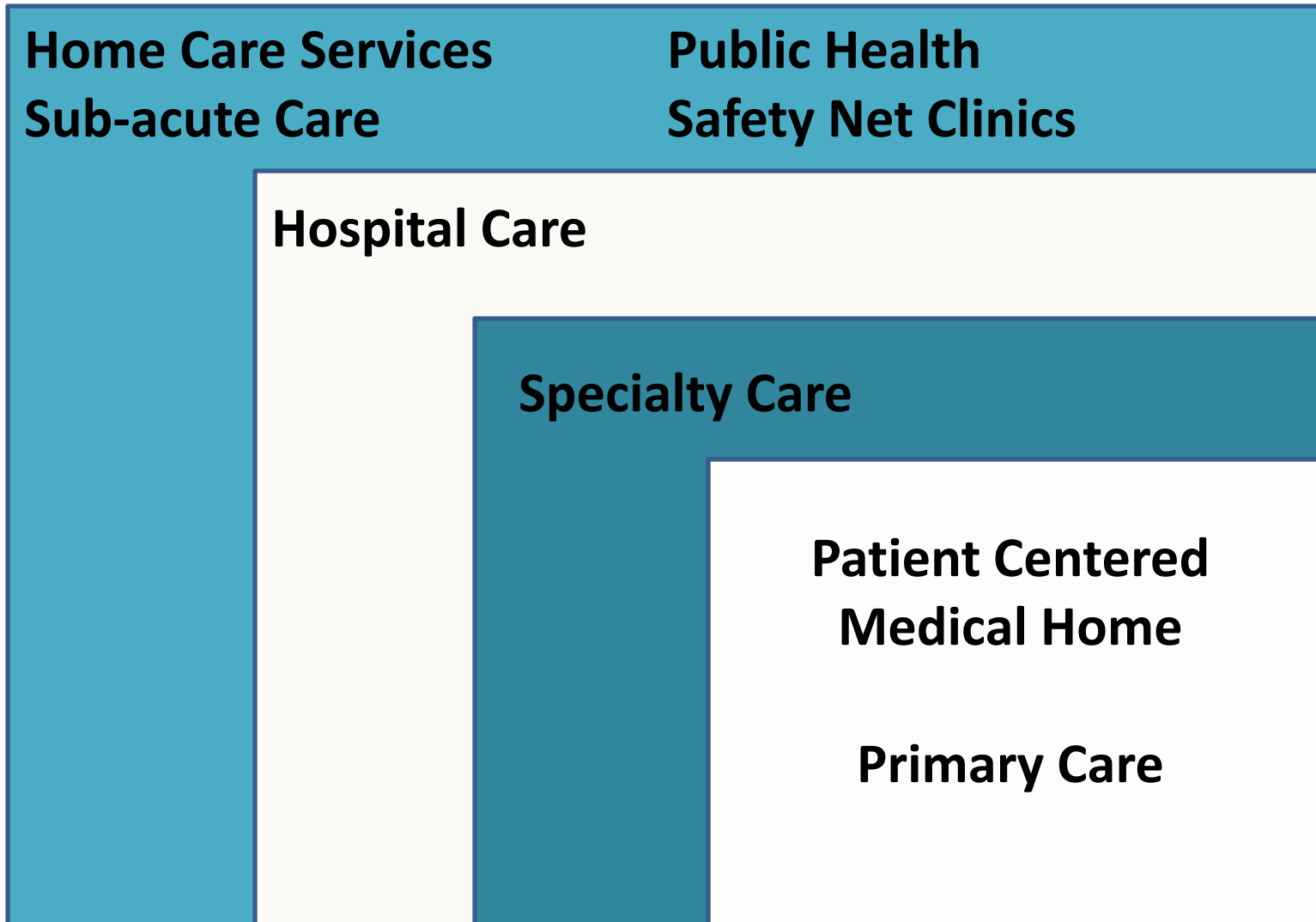
	All patients	HF	DM	CAD	High risk score
UM unadjusted	21.42	17.3	11.1	17.3	17.5
CG unadjusted	25.63	22.3	18.5	13.6	24.8
UM risk adjusted	6.5	5.8	6.7	0.4	3.4
CG risk adjusted	11.5	10.7	10.4	4.1	10.3

UM - University of Michigan
CG – Comparison Group

Managing Populations: Stratified Approach to Patient Care



Theory of ACO Development



Why Would an Academic Healthcare System Decide to Participate in Clinical Redesign?

- ▶ Prepare for a new business model, “Outcomes Based Payment” and provider risk
- ▶ Enhance health system capability for population management (cost and quality)
- ▶ Enhance provider-based care coordination and quality interventions
- ▶ Collaborate with leading physician groups & CMS
- ▶ Be leaders in healthcare delivery system redesign
- ▶ (Sometimes they have no choice)

A word about quality

32 Quality Measures in PGP Demonstration

Diabetes Mellitus		Congestive Heart Failure		Coronary Artery Disease		Preventive Care	
HbA1c Test	4	Left Ventricular (LV) Assessment	1	Antiplatelet Therapy	1	Blood Pressure Measured	1
HbA1c < 9%	1	LV Ejection Fraction Testing	4	Antihyperlipidemic Therapy	1	Blood Pressure < 140/90	1
Blood Pressure < 140/90	1	Weight Measured	1	Beta-Blocker Therapy: Prior MI	1	Care Plan if elevated BP	1
LDL Test	4	Blood Pressure Measured	1	Blood Pressure Measured	1	Breast Cancer Screening	4
LDL < 130	1	Patient Education	1	Lipid Profile	4	Colorectal Cancer Screening	1
Urine Protein Testing	4	Beta-Blocker Therapy	1	LDL < 130	1		
Eye Exam	4	ACE-I (inhibitor) Therapy	1	ACE-I if diabetes or LV systolic dysfunction	1		
Foot Exam	1	Warfarin - atrial fibrillation	1				
Influenza Vaccination	1	Influenza Vaccination	1				
Pneumonia Vaccine	1	Pneumonia Vaccination	1				
TOTAL Points	22		13		10		8

Quality Initiatives: *Physician Diabetes Feedback Report*

Patients with no A1C Test in Prior 6 Months

CPI	Name	Age	A1C at Close of			Most Recent Lab, Medication and Visit Data												
			Jul-Dec 04	Jan-Jun 05	Jul-Oct 05	On Insulin	LDLC Date/Result	Statin	BP	Proteinuria Date/Result	ACE or ARB	Foot Exam	Eye Exam	PC or Endo. Visit	Endocrinology Physician	Resident or Nurse Practitioner		
		55	6.7	9.0		Y	10/05	100	Y	121/67	10/05	pos	Y		04/04	07/05		

Patients with A1C > 7.0% in Prior 6 Months

CPI	Name	Age	A1C at Close of			Most Recent Lab, Medication and Visit Data												
			Jul-Dec 04	Jan-Jun 05	Jul-Oct 05	On Insulin	LDLC Date/Result	Statin	BP	Proteinuria Date/Result	ACE or ARB	Foot Exam	Eye Exam	PC or Endo. Visit	Endocrinology Physician	Resident or Nurse Practitioner		
		59			10.3		09/05	83		170/82	09/05	neg	Y	07/05	06/05	07/05		
		55	9.9	10.8	8.7		04/05	85	Y	127/77	04/05	neg		08/05	03/05	08/05		
		59	7.5		7.3		09/05	82	Y	149/84	09/05	neg	Y	09/05	07/05	09/05		

Patients with A1C <= 7.0% in Prior 6 Months

CPI	Name	Age	A1C at Close of			Most Recent Lab, Medication and Visit Data												
			Jul-Dec 04	Jan-Jun 05	Jul-Oct 05	On Insulin	LDLC Date/Result	Statin	BP	Proteinuria Date/Result	ACE or ARB	Foot Exam	Eye Exam	PC or Endo. Visit	Endocrinology Physician	Resident or Nurse Practitioner		
		65	6.4	6.0			06/05	94	Y	131/74	02/05	neg	Y	06/05	05/05	06/05		
		64	6.8		6.2		08/05	19		123/75	08/05	neg		08/05	01/05	08/05		
		55	5.5	5.5			10/05	126		110/64				10/05	04/05	05/05		
		39		5.5	6.0		01/05	55	Y	117/72				10/05	12/04	06/05		
		53	6.0	6.6	6.7		08/05	49	Y	114/78	09/05	neg	Y	05/05	07/05	09/05		

Clinical Initiatives – Quality

Site Diabetes Feedback Report

Site Name	N	A1C Test	A1C < 9%	LDL Test	LDL < 130 mg/dL	LDL < 100 mg/dL	On Statin	Monitor for Nephropathy	Urine Protein & on an ACE-I/ARB	Foot Exam	Eye Exam	B.P. < 135/80
General Medicine Group A												
Briarwood GM	760	93%	83%	96%	86%	66%	68%	74%	79%	47%	72%	49%
Canton GM	789	93%	81%	95%	83%	60%	65%	76%	80%	56%	64%	50%
Canton Med/Peds	161	90%	76%	93%	78%	58%	65%	88%	85%	62%	71%	52%
Chelsea GM	194	78%	75%	82%	72%	52%	59%	57%	81%	44%	40%	52%
Livonia GM	168	93%	82%	96%	85%	65%	67%	85%	84%	68%	68%	53%
Saline GM	180	91%	84%	96%	86%	71%	75%	80%	91%	70%	66%	44%
Turner Geriatric	376	89%	84%	87%	79%	61%	61%	72%	77%	37%	63%	52%
W. Ann Arbor GM	202	92%	85%	91%	84%	66%	71%	67%	96%	75%	80%	64%



Activate Patients

- Activate and educate patients by providing them with information on how they are doing at the time of their visit
- Insert patient data onto a take-home educational sheet

Patient Name:		CPI:	AGE:	
Appointment with:		Apptmt. Location:	DATE:	
		GMPCP-TC	54 4/6/2007 9:30:00	
Diabetes care: The ABCs to better health				
		How often	Ideal level	Your Result
	A 1c measures blood sugar control <i>Lowering your A1c reduces diabetes complications</i>	Every 3-6 months	less than 7%	10.1
	B lood pressure control <i>Lowering your blood pressure reduces strokes</i>	Every visit	less than 135/80	
	C holesterol (LDL) level <i>Lowering your LDL level reduces heart attacks</i>	Every year	less than 100 mg/dl	124
	D iabetes kidney microalbumin test <i>Treating early kidney damage may prevent dialysis</i>	Every year	less than 30 mg/gm	157
	E ye exam: if your last eye exam was abnormal if your last eye exam was normal <i>Detecting early eye damage may prevent blindness</i>	Every year Every 2 years		4/13/2006
	F oot exam <input checked="" type="checkbox"/> observe the feet <input checked="" type="checkbox"/> check pulses <input checked="" type="checkbox"/> test sensation <i>Helps prevent serious foot infections and amputations</i>	Every year		2/1/2007
	G oals for self-management <input checked="" type="checkbox"/> My goal: <i>Self management goal : send blood sugar into my office</i> <i>Helps you better control your diabetes</i>	Every visit		2/1/2007
	H ome glucose testing <i>Ask your doctor if this is right for you</i>	Varies		
	I mmunizations and Heart Medications <input checked="" type="checkbox"/> Influenza (<i>Flu vaccine</i>) <input checked="" type="checkbox"/> Pneumonia (<i>Pneumovax</i>) <input checked="" type="checkbox"/> Statins and Aspirin - <i>reduce heart attacks</i> <i>Immunizations help prevent serious infections</i>	Every year At least once Daily if needed		
	J ust ask for a referral to <input checked="" type="checkbox"/> Diabetes Education Classes <input checked="" type="checkbox"/> Nutrition Counseling <input checked="" type="checkbox"/> Weight Management Programs <input checked="" type="checkbox"/> Smoking Cessation Program	Varies		

Prepared by the University of Michigan Diabetes Quality Improvement Committee
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Quality (and efficiency)

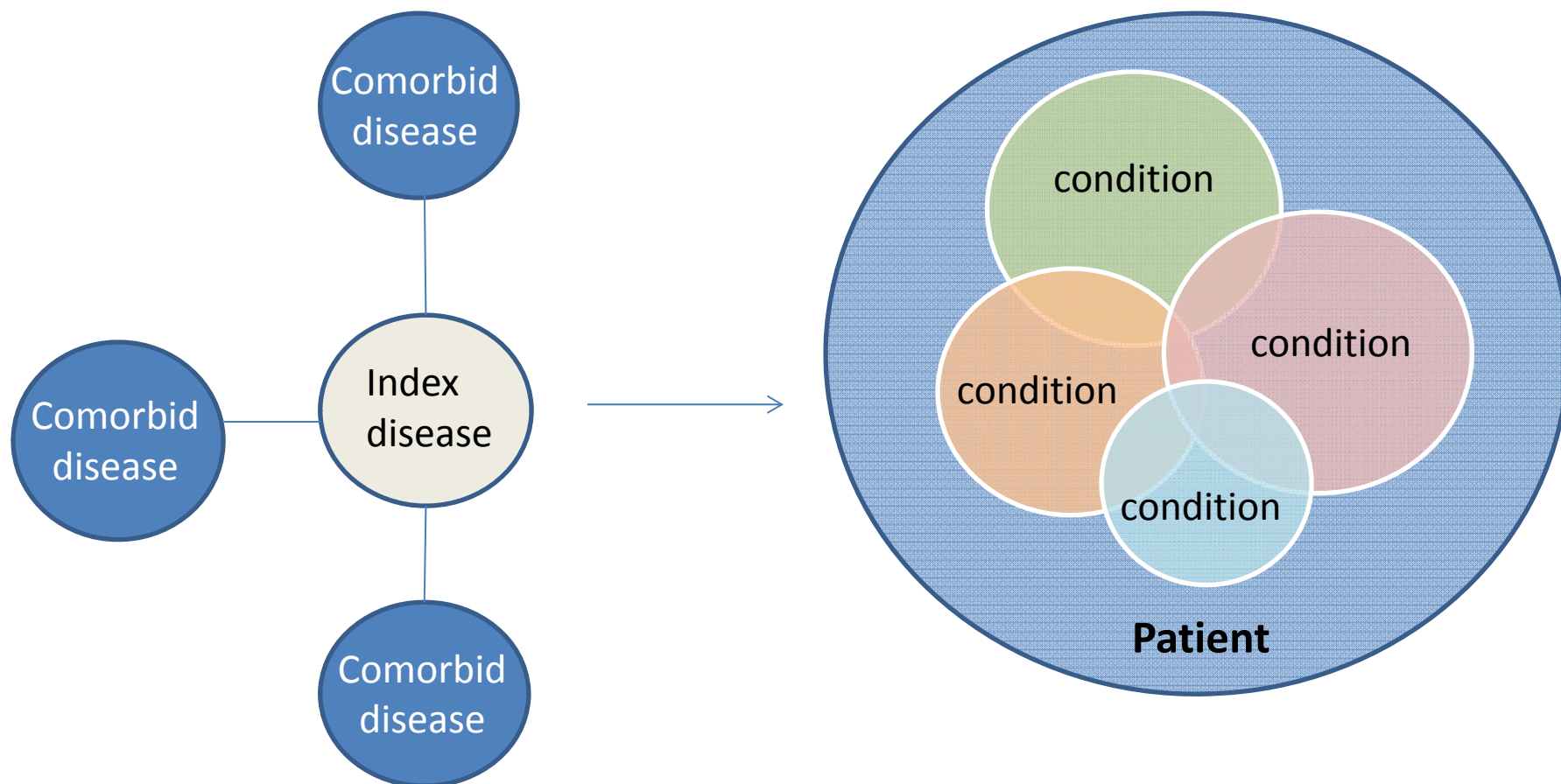
1. Many measures for ACO Demonstrations and Programs are new and untested with incomplete specifications.
2. 33 measures – publically reported but pay for reporting in the first year
3. Multiple domains:
 1. Patient experience – CAHPS
 2. Ambulatory clinical quality but includes composite measures and some new measures (falls, COPD, osteoporosis)
 3. Coordination measures – medication reconciliation, readmissions
 4. Utilization measures – ambulatory care sensitive admissions

Quality measurement is evolving

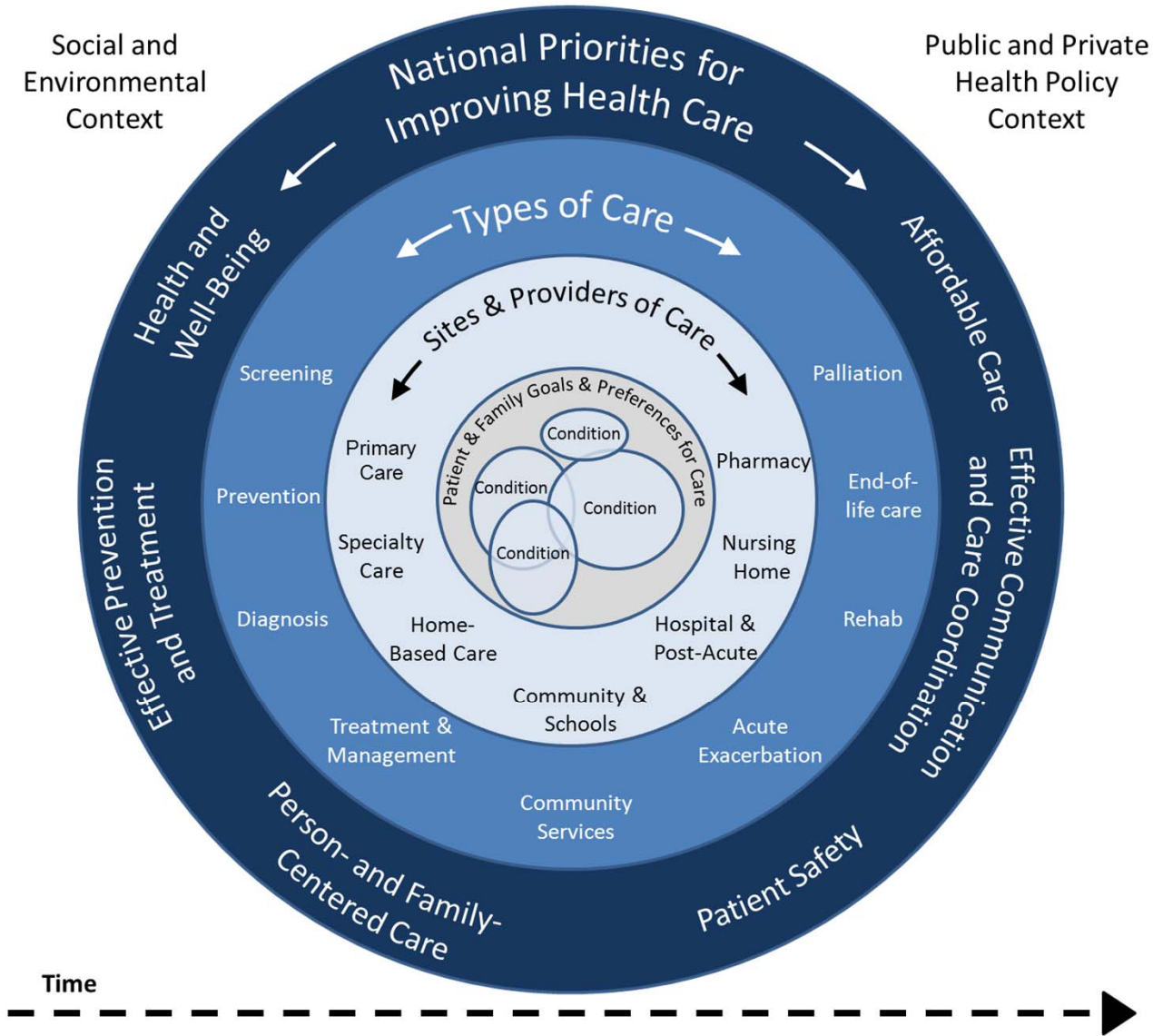
- Some favorable trends:
 - Geriatricians involved
 - Awareness of complex patients and frail elders
 - Evidence for overtreatment and competing risks
 - Aware of limitations with current measures
 - Desire for measures of function, patient-reported outcomes
- Concerning trends remain:
 - Forcing outcome measures when make no sense
 - Composite measures
 - Use of admission/readmission measures prematurely
 - Interest in episodes, one disease at a time approach
 - Interest in registries, one disease at a time

Model of multiple comorbidities

(Boyd, C. et al., *Public Health Reviews* 2010)



Quality Framework for People with MCC's



Summary

- Geriatric models of care and key principles inform delivery system redesign and healthcare reform
- Academic Healthcare Systems look to Geriatrics when they begin clinical redesign
- Geriatricians must:
 - understand key features of delivery system redesign
 - adapt models of care to their unique system
- Beware of poorly designed “organized systems of care”
- Get involved with Quality – shifting paradigm important for patients, families and Geriatricians

Summary – What about the Patients?

- Redesign must be patient-centered
- What do patients and families want?

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