Envisioning the Future: The Changing Environment For Care of Older Adults

2015 Reynolds Grantee 13th Annual Meeting
The Value Proposition for Geriatrics
October 14 – October 16, 2015

The John A. Hartford Foundation: A Legacy of Leadership in Improving Care for Older Adults

Terry Fulmer, President, PhD, RN FAAN
Thank you

To the Reynolds Foundation for sustained and impactful leadership in the field of aging
Who We Are
It is necessary to carve from the whole vast spectrum of human needs one small band that the heart and mind together tell you is the area in which you can make your best contribution.

John and George Hartford
Mission

Improve the care of older adults

Photo by Julie Turkewitz
Joined by important partners...
New Chair of Board

Peggy Wolff
Skadden Arps
10 member board
Aging & Health Commitment

$475,000,000

amount invested in aging and health since 1982... why?

Photo by Julie Turkewitz
The Context

Population age 65 and over and age 85 and over, selected years 1900–2010 and projected 2020–2050

Millions


NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012.

Reference population: These data refer to the resident population.

Why Aging & Health?

Adults over 65 represent 14% of the population, yet account for:

- 39% of all hospital stays
- 45% of all days of hospital care
- 34% of prescriptions
- 43% of hosp admits from ER
- 82% of home health care
- 80% of all deaths

Sources:

- *Retooling for an Aging America: Building the Health Care Workforce*, Institute of Medicine, 2008.
- CDC/NCHS, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey, 2013.
Preventable Adverse Events

**FIGURE 7:**
Serious Injury or Death, 2014

- Falls, 79
- Med Error, 7
- Neonatal, 6
- Test Results, 5
- Pressure Ulcers, 3
- Suicide, 5
- Other, 6
ADEs- the example of meds

Key Facts

• Adverse drug events (ADEs) are a serious public health problem. It is estimated that:

• 82% of American adults take at least one medication and 29% take five or more

• 700,000 emergency department visits and 120,000 hospitalizations are due to ADEs annually

• $3.5 billion is spent on extra medical costs of ADEs annually

• At least 40% of costs of ambulatory (non-hospital settings) ADEs are estimated to be preventable
Grantmaking Approach

• JAHF as leading national funder solely focused on aging and health mission

• Strategy driven

• Expert staff, engaged in the field

• “We don’t make grants... we make social change...”  R. Lavizzo-Mourey
Strategy

Improving care for older adults

Photo by Julie Turkewitz
Five Funding Portfolios*

Comprehensive, Coordinated, Continuous, and Expert Care to Improve Health of Older Adults

- Leadership in Action
- Linking Education and Practice
- Developing and Disseminating Models of Care
- Tools and Measures for Quality Care
- Policy and Communications

*matrix
Five Funding Portfolios

- Leadership in Action
- Linking Education and Practice
- Models of Care
- Tools and Measures
- Policy and Communications
Leadership in Action

- Empowering experts in geriatric care to make change in clinical and community environments that improves health for older adults.
  - JAHF Change AGEnts Initiative for broad engagement
  - Health & Aging Policy Fellows
  - Practice Change Leaders for Aging & Health
Training current practitioners in today's best care, building into education the skills needed for tomorrow's care.

- Gerontological Social Work Supervisors Program
- Improving the Health of Older Adults Using Integrated Networks for Medical Care and Social Services
- CoEs transitioning to the future
Models of Care

- Making evidence-based models that deliver quality care with better outcomes at a lower cost accessible to older Americans
  - Center to Advance Palliative Care (Meier)
  - Carealign - primary and specialty care redesign around pt goals & prefs (Tinetti, Blaum)
  - Hospital Elder Life Program (Inouye)
  - NICHE (Fulmer, Bricoli, NYUCN)
  - Care Transitions/Readmission Reduction (Coleman, Naylor)
Tools and Measures

- Promotes measures of quality, health information technology, and standards of care that support appropriate care for older adults
  - Quality Measurement to Assess the Performance of Goal Setting
  - Understanding Health IT-Enabled Performance Improvement for Older Adults
  - Geriatric Surgery Verification and Quality Improvement Program
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Lead Investigator/Institution</th>
<th>Funding</th>
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<tbody>
<tr>
<td><strong>Care Transitions Program®</strong></td>
<td>reduces likelihood of avoidable hospital readmissions. In use in 925 organizations across 44 states. Core of Community-based Care Transitions Program (ACA sec. 3026)</td>
<td>Eric Coleman, UC Denver</td>
<td>$750,000</td>
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<td><strong>IMPACT Evidence-based Depression Care</strong></td>
<td>doubles the effectiveness of standard depression treatment in primary care. More than 6,000 practitioners trained; implementation in &gt; 1,000 clinics nationwide.</td>
<td>Jürgen Unützer, U. Washington</td>
<td>$2,300,000</td>
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<td><strong>Center to Advance Palliative Care™ (CAPC)</strong></td>
<td>increasing availability of quality palliative care services for people facing serious, complex illness. Present in &gt; 90% of large hospitals, working to reach beyond.</td>
<td>Diane Meier, Mt. Sinai</td>
<td>$2,000,000</td>
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<td><strong>NICHE (Nurses Improving Care for Healthsystem Elders)</strong></td>
<td>reduces adverse events and functional decline. More than 620 member hospitals/systems, expanding to LTC.</td>
<td>Barbara Bricoli, NYU</td>
<td>$1,500,000</td>
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<td><strong>Hospital at Home®</strong></td>
<td>provides hospital-level care at home, reducing adverse events and length of stay, increasing satisfaction. Current CMMI Innovation Challenge Award replication at Mount Sinai, NYC</td>
<td>Bruce Leff/Al Siu, Mount Sinai/Johns Hopkins</td>
<td>$1,600,000</td>
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<td><strong>HELP (Hospital Elder Life Program)</strong></td>
<td>reduces incidence and severity of delirium, &gt; 200 hospitals in the US and internationally</td>
<td>Sharon K. Inouye, Harvard/HSL</td>
<td>$450,000 (planning grant)</td>
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<td><strong>Care Management Plus</strong></td>
<td>improves quality of chronic disease care and reduces rates of hospitalization, &gt;100 clinics adopting.</td>
<td>David Dorr, OHSU</td>
<td>$1,600,000 (concluded)</td>
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<td><strong>Geriatric Interdisciplinary Team Training</strong></td>
<td>Curricula to improve teamwork in education and practice</td>
<td>Terry Fulmer, NYU Nursing RC &amp; sites</td>
<td>$10.3m</td>
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<td><strong>Transitional Care Model</strong></td>
<td><strong>Reduces likelihood of avoidable hospital readmissions, improves cost and patient safety. Has been replicated under the Community-based Care Transitions Program (ACA sec. 3026).</strong></td>
<td><strong>Mary Naylor</strong>&lt;br&gt;U Pennsylvania&lt;br&gt;No current grant&lt;br&gt;$473,000 (concluded)</td>
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<td><strong>Acute Care for the Elderly (ACE) Unit</strong></td>
<td><strong>Provides the best inpatient care for hospitalized older adults with a focus on maintaining and improving physical and cognitive function. One of the evidence-based models embedded in NICHE Program.</strong></td>
<td><strong>C. Seth Landefeld</strong>&lt;br&gt;U Alabama Birmingham&lt;br&gt;(now)&lt;br&gt;$ 1.2m (concluded)</td>
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<td><strong>HomeMeds™</strong></td>
<td><strong>A technology-enabled intervention that addresses medication safety for older adults by connecting homecare and other community-based services to health care providers. Spread to &gt;40 sites. Expansion funded by ACL.</strong></td>
<td><strong>June Simmons</strong>&lt;br&gt;Partners in Care Foundation&lt;br&gt;$1.6m (concluded)</td>
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<td><strong>PACE (Program for All-inclusive Care of the Elderly)</strong></td>
<td><strong>Helps low income nursing home-eligible seniors maintain independence in the community through blended medical care and social supports delivered at PACE site. Federal grant supported rural PACE expansion. &gt; 100 sites across U.S.</strong></td>
<td><strong>Jennie Chin Hansen, On Lok</strong>&lt;br&gt;Peter Fitzgerald, NPACE&lt;br&gt;$434,000 (concluded)</td>
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<td><strong>Guided Care™</strong></td>
<td><strong>Specially trained Guided Care Nurse provides help primary care practices meet the complex needs of patients with multiple chronic conditions. In partnership with AHRQ and NIA. Johns Hopkins Nursing has trained 277 nurses trained in the Guided Care model; more than 609 physicians and practice managers were trained in 36 states.</strong></td>
<td><strong>Chad Boult</strong>&lt;br&gt;Johns Hopkins&lt;br&gt;$3.7m (concluded)</td>
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<td><strong>GRACE (Geriatric Resources for Assessment and Care of Elders)</strong></td>
<td><strong>Provides team care focused on geriatric assessment, treatment, care coordination and integration of pharmacy, mental health, and community-based social services. Reduced hospital readmissions. Replication include Avalere Health and Health Care Partners (Los Angeles).</strong></td>
<td><strong>Steven Counsell</strong>&lt;br&gt;Indiana U&lt;br&gt;Pilot support through CoE grant (concluded)</td>
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• Communication, advocacy, and research that inform the development of effective health and aging policies
  – Voices for Better Health: Geriatrics Provider Collaboration
  – Health Affairs Journal: Health & Aging series
  – Frameworks
  – IOM Family Caregiving Report Sponsorship
The Hartford Change AGEns Initiative aims to harness the collective strengths, resources and expertise of the John A. Hartford’s community of scholars and health systems leaders to accelerate sustained practice change that improves the health of older adults.
JAHF Change AGEnts
Hartford Change AGEnts Community
Supports and connects Hartford-associated clinicians, researchers and leaders to build their capacity to change practice and improve care for older adults. Activities include:

- **Online Platform**
- **Small Grants**
- **Skill-Building Webinars**
- **Change AGEnts Connect Program**
- **Annual Change AGEnts Convenings**
- **Open Forum Announcements, questions and discussion**
- **Change AGEnts Directory**
- **Action Awards**
- **Action Community**
  A virtual forum for Change AGEnts to collaborate on a shared practice interest and exchange ideas, resources and opportunities.

Hartford Change AGEnts Networks
Interprofessional workgroups of 12-14 experts of Change AGEnts who will implement a sustained practice project(s) to improve the way care is delivered to older adults. Each Network aims to spur innovations in practice, delivery systems, workforce, regulation and policy, as well as partnerships with organizations or national health care movements.

- **Dementia Caregiving Network**
- **Patient-Centered Medical Home Network**

- **Change AGEnts Conference**
- **Policy Institute**
- **Communications Conference**
- **Action Awards Institute**

- **www.changeagents365.org**
So why does it matter?

- 14% of population over 65 and growing
- Care models are not in place
- Dementia care will skyrocket - who will provide the care? What will their salary be?
- Who will suffer?
- Who will monitor?
JAHF Change AGEnts

How you can be involved:

• Join the Community & participate online
• Register for a skill-building webinar
• Apply for an Action Award
• Attend annual Policy Institute, Communications Institute, Change AGEnts Conference

• Learn more at: http://www.changeagents365.org
WHCOA in July 2015

Four (4) national priorities chosen relevant for aging:

• Retirement Security
• Healthy Aging
• Long Term Services and Supports
• Elder Justice
Having access to services and supports can be critical to improving quality of life, maximizing independence, and preventing hospital re-admission. Services and supports can include assistance with dressing or cooking, social
Thank You for Inviting Me!