VHCIP Frail Elders Project

http://www.vmsfoundation.org/elders

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http://healthcareinnovation.vermont.gov/

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Target Population

Seniors at risk of a decline in the quality of their lives or a poor health outcome

Global Aim

Identify barriers to best primary care for high-risk elders in 2 rural communities and Recommend:

1) **Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients;**
2) **Payment innovations to support the redesigns; and**
3) **Measures to track changes in outcomes that matter to patients.**

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Research Focus Areas

1. **What characterizes a frail or high risk senior?**
2. **What are the characteristics of their service utilization?**
3. **What matters to seniors?**
4. **Are there care models known to produce better value (outcomes/cost)?**
5. **What systemic barriers to providing care exist?**
6. **What aspects of the delivery system are and are not working locally?**
7. **How could the local delivery system be improved?**
8. **What are practical and meaningful measures of value? (things that matter to patients/cost of meaningful episodes of care)**
9. **What are unnecessary costs and how could they be reduced?**
10. **How can payment reform support the achievement of things that matter to patients?**

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5 Research arms

- **Structured interviews/focus groups– elders/caregivers; home bound**
- **Literature search/UVM Medical Library**
- **33 provider interviews**
- **5 policy/subject matter experts**
- **VT Household /CMS Current Beneficiary Surveys (MCBS)**

5 Reports

- **What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review**
  http://www.vmsfoundation.org/elders/matters
- **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**
  http://www.vmsfoundation.org/elders/atrisk
- **Caring for Seniors: An interview Study**
  http://www.vmsfoundation.org/elders/caring
- **What Survey Data Tell Us**
  http://www.vmsfoundation.org/elders/surveydata
- **Final Report and Recommendations**
  http://www.vmsfoundation.org/elders/recommendations

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Remarkably consistent themes in findings across all 5 research arms:

- **Mismatches between what gets paid for and what's important to seniors;**
- **Today's payment policies create significant inefficiencies/harm VT's seniors;**
- **Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;**
- **Physical health matters to seniors, but remaining at home, retaining autonomy, not feeling like a burden matter at least as much;**
- **Care should go to patients, not patients having to come to care;**
- **Control over health care budgets needs more community level influence;**
- **Primary care is in critical condition, we all need to rethink how to support it;**
- **There are proven examples of how to do it better; and**
- **There is a lot that can be done right now!**

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Our recommendations are presented as answers to four core questions:

1) **Who are our high risk seniors?**

2) **How will we measure success?**

3) **How will we care for them?**

4) **How will we pay for their care?**

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1) Who are our high risk seniors?

Research findings highlight the following -

- **Multiple chronic conditions**
- **Functional impairment**
- **Impaired mobility, gait and balance problems**
- **cognitive impairment, depression**
- **high utilization of health care and social services**
- **More likely to be low-income, live alone, lack caregiver availability, and lack an adequate support system of family and friends**
- **Social determinants of health as critical factors in the well-being of seniors**

And how will we identify them?

The Research Team recommends -

- **A 3 step identification process**
- **Billing data and structured data in medical records analyzed by a predictive algorithm**
- **Risk stratified based on significant events, high utilization patterns, key diagnoses, social determinants of health and impairment in ADLs and IADLs**
- **Reviewed for appropriateness by a dedicated practice seniors' care team**
- **Practice team members can recommend additional patients known to them to be at risk of poor health outcome or a decline in the quality of their lives**
- **Partner community support service providers invited to recommend others**

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2) How will we measure success?

<u>The Research Team recommends -</u>

- **A multi-dimensional balanced evaluation, e.g. Clinical Microsystems Value Compass**
- **No single index of success is sufficient**
- **Existing validated metrics directly relevant to the process or system being evaluated**
- **Annual ongoing comparisons to appropriate benchmarks rather than pre and post measures**
- **Social, clinical, mental health, substance use, healthy behaviors (diet, exercise) as it relates to a person's ability to maintain or improve their health**
- **Functional measures - patient reported outcomes ADLs, IADLs**
- **Measures of patient goals being met**
- **Measures of independence with sufficient self-management support**
- **Provider reported measures directly related to the systems of care and the care needs of this population of patients**
- **Utilization, financial measures - hospitalizations, ED visits, long term SNF placement and claims paid**

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3) How will we care for them?

Multidisciplinary Primary Care Team including senior and family

- Shared Care Plan across all providers
- Home based care

Neighborhood Team

- Practice team and representatives of appropriate community support and service providers
- Reviews new/emergency cases and periodic reviews of all high-risk seniors

A third layer of community coordination

- Practice and community partners
- Adequacy of the overall needs of the community's seniors
- Advocacy for their senior citizens

Special practice status "Gold Team"

- Priority same-day appointments
- Home visits by practice team
- 24/7 access to someone they know
- Group medical visits
- Gold Team membership will promote sense special place in practice; foster a sense of a community group; raise community awareness of the program
- Enhanced services will decrease inappropriate calls to 911 and unneeded hospitalizations
- Individualized Care Plan

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4) How will we pay for their care?

The paramount aspect of payment reform is that a payment methodology should be the last question to be addressed. What matters to seniors as presented in the project findings needs to always be of primary importance and the final guide to any decisions about care model design, measures of success and funding mechanisms to support care.

The Commonwealth Care Alliance Senior Options Program

http://commonwealthcaresco.org/

The Independence at Home Project

https://innovation.cms.gov/initiatives/independence-at-home/

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- **Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;**
- **Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;**
- **When possible, care should go to patients rather than patients having to come to care;**
- **Control over health care budgets needs more community level influence;**
- **Primary care is in critical condition, and we all need to rethink how to support it;**
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