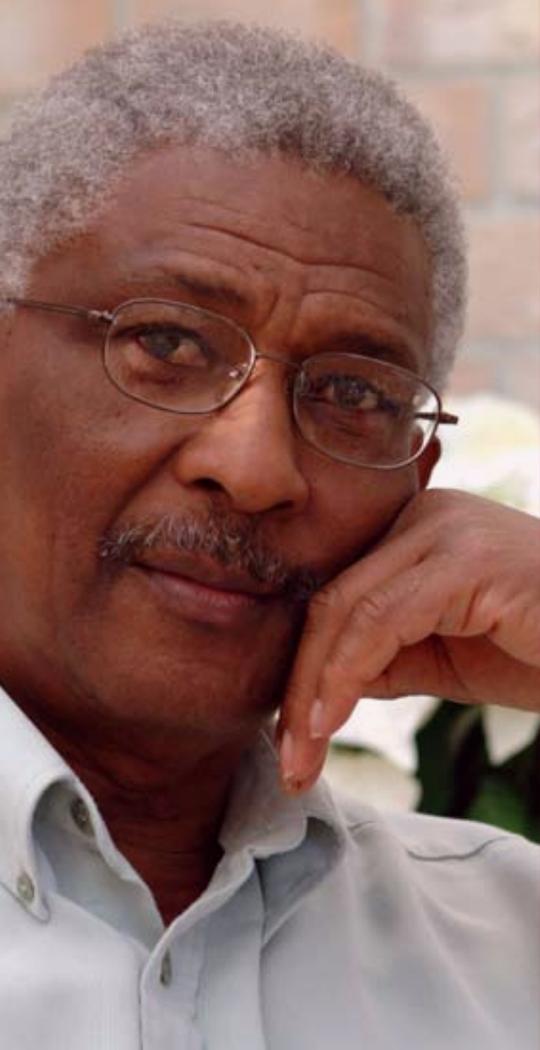




Toward a Care Coordination Policy for America's Older Adults

AN OVERVIEW AND RECOMMENDATIONS FOR PRESIDENT-ELECT BARACK OBAMA AND HIS TRANSITION TEAM

National Coalition on Care Coordination [N3C]
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**INTRODUCTION:**

The National Coalition on Care Coordination (N3C) was formed in 2008 to promote better coordinated health and social services for older adults with chronic conditions. N3C is comprised of leading social, health care, family caregiver and professional organizations. This document makes recommendations for changes to the current care systems for America's aging population which will lead to lower cost and improved quality of care.

RECOMMENDATIONS:

The N3C recommends the following actions by the Obama Administration to promote and implement care coordination services¹ either through administrative action or proposed legislation:

Replicate and expand care coordination demonstration projects to:

- Include pay-for-performance measures related to quality of care coordination services within any future demonstration projects on care for people with complex chronic illness; and
- Modify existing “medical home” and other demonstration projects, using administrative mechanisms within your executive authority, to:
 - Require that participating practices provide care coordination services which are “integrated” and “cross-discipline,” as mandated in the authorizing legislation;
 - Include coordination of long-term supports and services; and
 - Employ the expertise of professionals such as nurses, social workers, pharmacists, and others.

Provide for appropriate care coordination services under Medicare, Medicaid, and in health care reform proposals including:

- Coordination of care including health, social and long-term services and supports in addition to medical services;
- Payment to qualified professionals for periodic comprehensive geriatric assessments and care coordination for targeted at-risk populations, including payment to nurses, social workers and others who coordinate and optimize care between clinician visits; and
- Required standards and qualifications for providers of care coordination services (Preferred practices and measures being developed by the National Quality Forum could inform these standards²).

The Centers for Medicare and Medicaid Services (CMS) should work with AHRQ, NQF, and other experts to develop standards for care coordination with appropriate measures to evaluate them.

Analyze care coordination services in the Federal Long-Term Care Insurance Program (FLTCIP)³ including utilization and claims data to date, to inform provision of future benefits. Assess whether the services are effective and determine whether any new care coordination features which have the potential to improve quality and reduce costs should be:

- Incorporated into the new FLTCIP when a new contract is awarded in 2009; and
- Considered in health care reform proposals for universal health care.

THE CHALLENGE:

By 2030, one in five Americans will be 65 or older. Meanwhile, costs for health and long-term care services are escalating. The services that do exist are a bewildering maze of uneven quality and often duplicated, wasteful efforts. As a result, many older adults, including the most vulnerable—the frail elderly and those with chronic diseases—don't receive the care they deserve, or are unnecessarily hospitalized or institutionalized. The cost and inefficiencies also exact enormous financial, emotional and physical tolls on the 34 million family caregivers who provide the bulk of care to the aging.

**THE SOLUTION:**

Meeting this challenge head on will require care coordination—a client-centered, *assessment-based, interdisciplinary* approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following set standards of care. It improves the quality of care and life for older Americans, and has the potential to produce considerable savings by reducing hospitalizations and reliance on nursing homes. Care coordination also relieves caregivers so they don't lose work days to care for older loved ones and can maintain their own well-being.

Care coordination provides older adults with a degree of *control* over their lives and helps them maintain their independence for as long as possible in the *community* instead of relying on institution-based care. President-Elect Obama has himself suggested the need for care coordination within any national health care reform.

Short-Term Impact: Care coordination can improve care for some of the 20% of Medicare beneficiaries who suffer from five or more chronic conditions and account for almost 70% of all Medicare spending. This most vulnerable population is made up of individuals with chronic conditions who live at home or in nursing homes and those who are making transitions between health care settings.

Longer-Term Impact: Care coordination can prevent and perhaps reduce unnecessary costs for this 20% of Medicare beneficiaries. It also has the potential to lower overall spending while improving care for all. Targeted, coordinated care provides optimum services and prevents the overuse or misuse of care. The result: educated consumers, both older adults and their families.

THE BARRIERS:

- *Separate and fragmented service delivery systems* that don't communicate well with each other, much less with their intended beneficiaries. These systems require separate and recurrent application processes, and provide services that have more gaps than overlaps, thus causing significant stress for both older adults and their family caregivers.
- *A payment system limited to fee-for-service* that lacks incentives for clinicians, hospitals and other providers to provide coordinated care to people with multiple chronic conditions.
- *Separate and fragmented payment systems* that force people to draw from Medicare, Medicaid, Department of Veteran's Affairs, Older Americans Act and a variety of other state and local sources.

THE BENEFITS OF CARE COORDINATION:**Care coordination can:**

- Improve quality of care and life for older adults by improving communication among providers, older adults and families, streamlining services, eliminating duplication and confusion, and connecting older people with appropriate care.
- Reduce stress on family caregivers who now provide the bulk of care for their loved ones.⁴ By attempting to coordinate fragmented care on their own, many caregivers compromise their own physical and mental health, as well as missing workdays that cost U.S. businesses an estimated \$11 to \$39⁵ billion yearly in lost productivity.
- Reduce costs by helping people obtain all and only the services they need, when they need them, in the most effective manner possible, while minimizing duplication and gaps. This reduces use of costly acute care and nursing homes.
- Play a significant role in improving care quality and reducing costs for vulnerable populations by expanding services and integrating care delivery with evidence-based medicine, a goal of *Retooling for an Aging America: Building the Health Care Workforce*, an Institute of Medicine report released in April 2008.⁶



BACKGROUND

1. America is aging.

As baby boomers approach retirement age, both they and their parents are living longer than previous generations. By 2030—the year the youngest baby boomer is eligible for Medicare— those 65 and over will double to more than 70 million, or 20% of the total U.S. population. The “oldest old” are projected to number 9.5 million.⁷

2. The costs of health care and long-term care are escalating.

Overall health care spending is projected to increase 25% by 2030. The aging of the population and increased longevity is part of that surge;. As the Congressional Budget Office emphasizes, increased and often unnecessary use of health services is also a critical factor.⁸

Twenty percent of Medicare beneficiaries suffer from five or more chronic conditions and account for almost 70% of all Medicare spending.⁹ Those suffering from chronic conditions or making transitions between settings are the appropriate targets of care coordination. Coordinated care can help them obtain the right care in the right settings, while limiting care that drives up expenses without actually benefiting older adults’ overall health and well-being, or reducing their longer term need for expensive services.

3. Financing for health care is constrained by its fee-for-service incentives.

Medicare was created in 1965 to pay hospitals and doctors, but did not include long-term or coordinated care. The “current system of payment essentially segments the population by the provider whose services the patient is using at the moment—for example a nursing home population, a hospitalized population, a home care population, or an office-based care population. The results are dehumanizing and produce discontinuous, wasteful and unreliable care.”¹⁰

Within this provider-based payment scheme, the reimbursement incentives are geared to specific, episodic patient services, not the coordination of interdisciplinary continuous care to effectively manage multiple chronic conditions and reduce reliance on acute interventions. As the April 2008 IOM Report notes: “a major problem is that brief visits are a poor way of managing chronic conditions...Furthermore, under the FFS [fee-for-service] system more visits lead to higher physician and hospital revenues regardless of the quality or the efficacy of the services...Payment is directed to individual physicians and emphasizes treatment for in-person care, which serves as a barrier to care coordination...”¹¹

The report concludes that such payment provides no financial incentive for health care providers to deliver services that extend beyond the typical office visit, such as ongoing patient education to teach older adults how to better manage their chronic conditions.¹²

4. Chronically ill older adults need care coordination that includes social and long-term care services in addition to better coordinated health services.

To remain in the community, older individuals often need assistance with the activities of daily living. They also need direct and indirect financial support, help maintaining a home, social services and support, transportation, financial planning, legal services and other forms of assistance. Medicare does not pay for these services in the doctor’s office or in the community except for limited periods in hospice, discharge planning and skilled nursing care episodes. Services from other sources (Medicaid, private payment and long-term care insurance, Administration on Aging, Department of Veterans Affairs and other federal,



state and local funding) are available but are neither integrated nor adequate. The end result is a patchwork—with many patches missing.

5. Most health and long-term care for older adults is provided by unpaid, informal caregivers—many of whom also work full time.

Most day-to-day care of vulnerable older people is not provided or paid for by the patchwork that exists. Families and friends give unpaid, physical and personal care and support with an estimated value of \$375 billion a year—as much as the full annual cost of Medicare OR of Medicaid.¹³ The typical caregiver is a 46-year-old married woman with some college education, who provides at least 20 hours a week of unpaid care, personal as well as medical, to someone over the age of 50, often her mother.¹⁴ Many also have children and most work at some point during their caregiving years. They may cut down their work hours, leave jobs, lose their own health insurance and deplete their savings to provide care for a parent. About a third of them define their own health as fair to poor.¹⁵ For these caregivers the physical and mental stresses of caring for their parents can be literally debilitating.

6. Care coordination is an important way to improve care of the vulnerable aging—those with chronic conditions and those in acute care episodes—and to lighten the load on family caregivers.

Health services and long-term care services are so fragmented and difficult to access that they put an immense strain on the aging and their caregivers alike. These “systems” are internally disorganized and do not communicate well with each other, much less with “outsiders,” the beneficiaries for whom the services are intended. Multiple intake and assessment processes tax the caregivers of older adults. Sorting out whether medications from one doctor or hospitalization can be used with those already prescribed can be a daunting task. Fragmentation thus puts vulnerable older adults at increased risk of declining health and functioning, unnecessary suffering and institutionalization. Even when self-directed home-based community services improve the situation of consumers and caregivers, there is still a need for professional assistance in navigating both the acute care system and the network of community services. In 2007, the AOA found that caregivers would choose care coordination over respite care to alleviate the stress they experience.¹⁶

7. Elements of care coordination

The coordination of care must be carried out by an interdisciplinary team in a continuous way, thus staving off acute episodes. Research by the Social Work Leadership Institute/New York Academy of Medicine analyzed existing models of care coordination and identified six elements of care coordination:¹⁷

- ***Be Client Centered:*** quality care coordination must always start by listening to and respecting clients’ goals, desires, and preferences in decisions about care;
- ***Be Assessment Driven:*** services delivered or recommended should be based on a comprehensive, current assessment of the client’s health and psychosocial needs, including evaluation of caregiver supports;
- ***Have a Comprehensive Care Plan:*** the assessment of the client should inform development of a plan which outlines coordination within and between health, mental health and social service systems;
- ***Conduct Ongoing Evaluation:*** care coordination is an ongoing process, which requires a continuing relationship between the client and coordinator who follows the client through all settings;
- ***Include a Qualified Care Coordinator as Part of an Interdisciplinary Team;***
- ***Be Accessible:*** to maximize the transformative potential of care coordination, care coordination should be available to clients regardless of insurance coverage.



8. Demonstration and other projects funded through various sources provide examples of effective models for the care of larger older adult populations, particularly those with multiple chronic conditions living in the community or and those making transitions between care settings.

U.S. Department of Veterans' Affairs

(1) Geriatric Evaluation and Management (GEM)

GEM has been a leader in care coordination for older and disabled veterans for several decades. The goal of the program is to help older adults maintain or improve functional abilities and avoid nursing home placement. The GEM program utilizes an interdisciplinary team approach to coordinate care for older adults with complex needs.¹⁸ Members of the interdisciplinary team assess caregiver and client needs and create a coordinated plan of care that includes mental health, health and social services along with patient education.

The GEM program has been extensively evaluated and demonstrated reduced costs and positive patient outcomes. For example, the program has shown improvement in mental health for geriatric outpatients with no additional costs.¹⁹ Participation in GEM has also been shown to slow participant functional decline.²⁰

(2) VA Care Coordination

First instituted in 2002, this program is now offered at all VA medical centers. It relies heavily on technology, allowing care coordinators to remain in close contact electronically with patients in widespread geographic regions. Like GEM, this program is centered on an interdisciplinary team usually consisting of a social worker and a nurse who have direct contact with primary care physicians and specialists. Care coordinators have access to patient medical records and follow patients across episodes of care. Low-risk patients are monitored by telephone, while high-risk patients have in-home devices for tracking blood pressure, blood glucose levels, and other clinical indicators.²¹

Despite its relatively short existence, the **VA Care Coordination** program has already shown substantial reduction in emergency room visits and nursing home placements. As an additional step in coordinating care for older and disabled vets, particularly those at risk for Medicaid spend down, the AOA has recently given grants to 22 states for demonstration projects in which these veterans are connected to State Office on Aging care coordination programs, from which the VA is directly purchasing services.²²

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS)

(1) PACE: Program for All-inclusive Care for the Elderly

First implemented in 1983, **PACE** provides care coordination through community-based programs paid for by Medicaid and Medicare waivers; funds from these programs are pooled and used for any recipient, giving the program the flexibility to deliver services in the most efficient and effective manner. As of June 2006, the total number of **PACE** enrollees was nearly 11,000 individuals in 23 states.

Today's **PACE** programs are based on interdisciplinary care coordination teams, the use of adult day care centers, and the delivery of services to beneficiaries who are 55 years or older and nursing home eligible. Monitoring and re-evaluation is performed on an ongoing basis. **PACE** provides all Medicare and Medicaid health services, and, at a minimum, social services,



restorative therapies, personal care and supportive services, mental health services, nutritional counseling, recreational therapy, and meals, delivered in an adult day health center, home or inpatient facility. Nearly 50% of **PACE** participants have been diagnosed with dementia, yet 90% remain in the community.

The **PACE** program has been associated with cost savings for Medicare. The IOM report noted that, for **PACE** participants, capitated Medicare payments were 42% lower than projected Medicare FFS payments, although this did not hold true for Medicaid.²³ Much of this saving is, again, due to decreased use of acute in-patient care and nursing homes; **PACE**'s frailest patients have lower rates of both and higher rates of ambulatory care.²⁴

(2) Medical Home

A model originally developed for the care of children with chronic conditions, the “**Medical Home**” has been refined to serve the aging by the American College of Family Physicians and other physician groups as the Patient Centered Medical Home.²⁵ The basic premise of the Medical Home is that care managed and coordinated by a personal physician with the right tools will lead to better outcomes. This requires a basic shift in the relationship between patients and doctors.

In 2008 Congress funded Medicare demonstration projects of **Medical Home** that will start in early 2009. Solo physicians or group practices which demonstrate that they can provide services, including continuity of care, decision support, patient/family engagement and care coordination, become medical homes. The physician is the leader of the team, but the care coordination functions may be delegated to a nurse or social worker.²⁶

The proposed Medicare payment structure for medical home includes (1) a monthly capitated care coordination payment; (2) a visit-based, fee-for-service component and (3) a performance-based component that recognizes achievement of quality and efficiency goals.²⁷

Federal Administration on Aging: Wisconsin Family Care Aging and Disability Resource Centers (Point of Entry)

Single Point of Entry (**POE**) programs are funded under the Older Americans Act and run by many state and area agencies on aging.²⁸ The **Wisconsin POE** includes Medicaid and state funds as well as those from the Administration on Aging. This program was part of a major redesign of the state's long-term care system, including the creation of the Division of Disability and Elder Services that manages all Medicaid waiver Home and Community-Based Services and institutional care for older adults and people with disabilities.²⁹

Clients enter the long-term care system by calling or visiting the **POE**, an Aging and Disability Resource Center (ADRC) or by visiting the ADRC website. While the state mandates that each ADRC provide a certain range of services, including information and referral services, the organizational structure and funding of the ADRCs varies by county. In most cases, the ADRC includes collaboration between Area Agencies on Aging (AAAs, local divisions of the State Office on Aging) and county social service agencies. In this system, care coordination is provided by an interdisciplinary team made up of a social worker and a nurse who assess client needs and provide or arrange for needed services. Care coordination contractors receive a monthly per-client fee for all their clients. A variety of funding streams, as well as private pay, cover the costs of needed services: the **Wisconsin POE** system is considered very successful in attracting private pay clients. Wisconsin has noted that local aging agencies are naturals to develop ADRCs precisely because they have not historically had a focus on public benefits and therefore attract



older people who might not approach a welfare agency. At the same time, AAA staff has had the difficult challenge of learning public benefits.

✚ **State-Funded Program: New York State’s Expanded In-home Services for the Elderly (EISEP)**

Instituted in 1985, **EISEP** funding is exclusively from New York State and its localities. **EISEP** clients are 60 and older people who need help with everyday activities (such as dressing, bathing, personal care, shopping, and cooking), who want to remain at home, and are not eligible for Medicaid. Clients are required to cost share according to a sliding scale—from no cost to full cost—reflecting their income and the cost of the services they receive. **EISEP** services include mandatory case management, non-medical in-home services such as housekeeping, personal care and respite care. **EISEP** is one of the few care coordination programs in the country that includes respite care. Ten percent of its funding is available for ancillary services, or whatever the case managers find useful to help a client, from shoveling snow to repairing a roof.³⁰ The services of professionals support and supplement informal care provided by clients’ families. It is administered by local Area Agencies on Aging.³¹

✚ **Foundation Funding: Care Transitions and Transitional Care**

With funding from the John A. Hartford and Robert Wood Johnson Foundation, the University of Colorado Health Sciences Center’s **Care Transitions**³² model addresses the difficulties “patients, especially older persons, face when moving from one level of care or practice setting,”³³ “or when a patient is discharged from the hospital and goes home or to an assisted living or skilled nursing facility.”³⁴ **Care Transitions** is designed to reduce mishaps around discharge from a hospital to home or nursing home. It has four main features: a patient-centered personal health record to aid interdisciplinary communication during the transition period; a structured checklist of critical activities for the patient; an education session in the hospital for the patient and family with a transition coach; and follow-up visits by the transition coach in the new environment.³⁵

A major focus of **Care Transitions** is the empowerment of the patient or, as the case often is, the informal caregiver who uses the health record, has a medication management system, schedules follow-up visits, and learns to identify red flags that a condition may be worsening as well as possible side-effects of medications. A transition intervention is usually four weeks long. Each care coordination coach sees 350 patients annually, generating a conservative savings of \$300,000 a year per coach.³⁶ The model was formally tested using nurses as care coordination coaches. The **Transitional Care** model, developed by Mary Naylor of the University of Pennsylvania School of Nursing and funded by the Commonwealth Fund as well as the Jacob and Valeria Langeloth, John A. Hartford, and Gordon and Betty Moore Foundations, has also had cost-effective improvements in patient care using nurses to assess and provide home and other services during the two months after an individual has been released from the hospital.³⁷ **Care Transitions** has moved away from a requirement that the coaches be from a particular profession. Rather, the requirement is for professionals (including social workers) who are able to coach rather than implement directly, have some knowledge of medications, and know how to help a patient or family member be persistent but not a pest.³⁸

¹ See Section 7 of *Background* in this document for a complete list of care coordination elements.

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¹¹ *IOM Report*: 96 (references omitted).

¹² *Ibid.*

¹³ *Valuing*: http://www.aarp.org/research/housing-mobility/caregiving/dd158_caregiving.htm . (accessed 10/30/08).

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