Long-Term Care: Past, Present and Future

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Disclosures

- Consultant: BCAT and Brain Test
- Data Safety and Monitoring Board: Lilly
- Advisory Committee: Biogen, Genentech
- Wife owns stock in Pfizer and Johnson & Johnson

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Learning Objectives

- Analyze industry and patient trends in post acute and long term care settings
- Consider medical practice opportunities that will shape the future for primary care and geriatrics
- Assess the value of accountable care and population management
- Focus attention on safety and what the individual practitioner can do to mitigate risk
- Think strategically in your professional career

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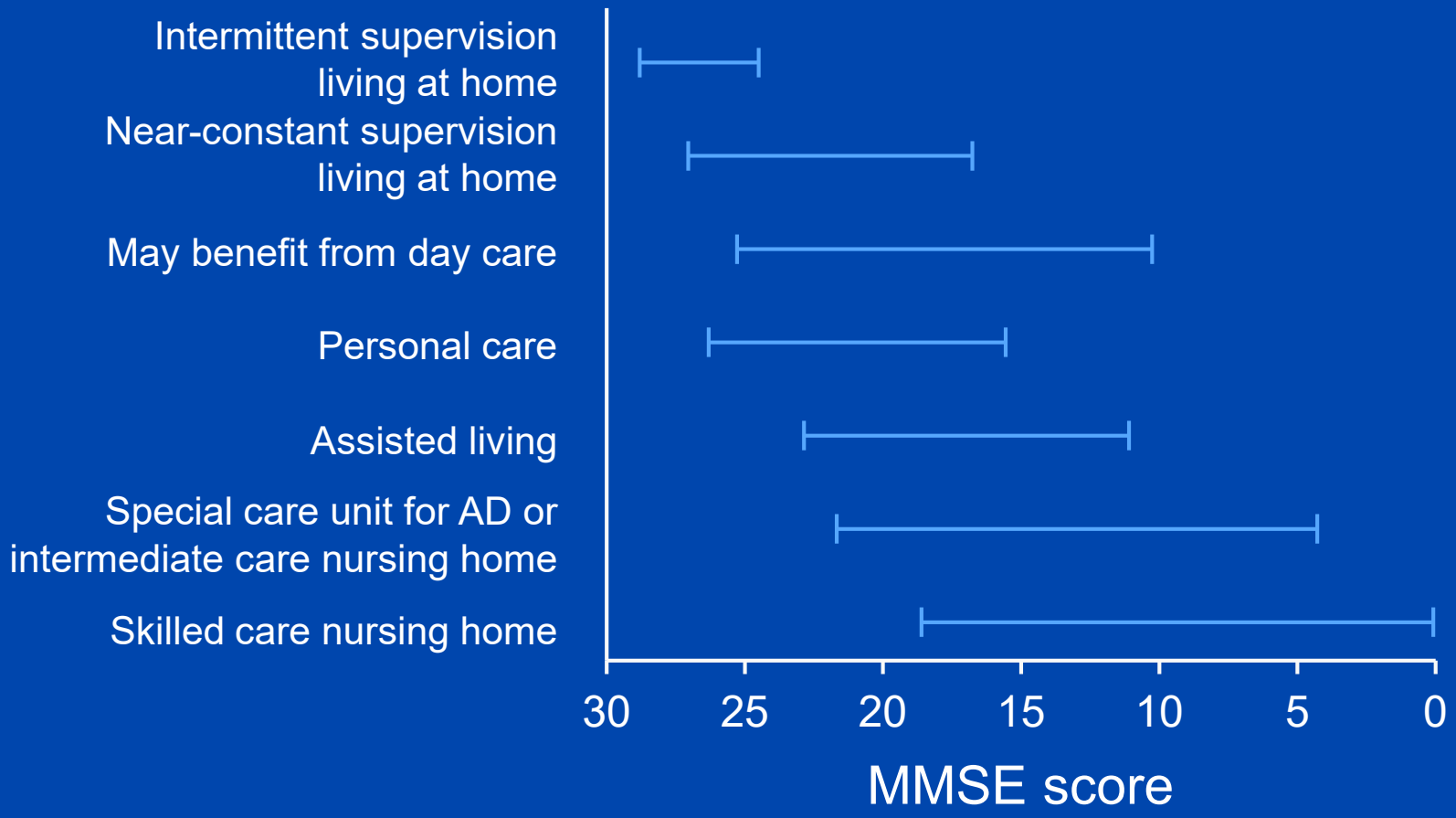
Care of patients with dementia is delivered in multiple sites



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Preparing for Medicare Fee-for-Service Payment Reform

- CMS will continue to finalizing payment systems for both skilled nursing facilities (SNFs) and home health agencies (HHAs)
  - In both sectors, payment reform focuses on replacing therapy-driven payment with payment that is based in large part on patient characteristics
  - CMS is giving both SNFs and HHAs over a year's prior notice, meaning 2019 will be a time for preparation including staff training, review of the provision of therapy, mastery of assessment instrument items, and ICD-10 codes
- For SNFs, it will also mean that length of stay will be a new consideration for some patients requiring therapy, while HHAs will now have to master the implications of 30-day episodes instead of the previous 60-day episodes

Value-based Payment

- Driven by the physician payment law, 2019 will not only see continued momentum towards Advanced Alternative Payment Models (APMs), but also a push towards having these models incorporate downside risk in order to drive lower costs and increase quality.
  - Through its “Pathways to Success” proposal, CMS is pushing accountable care organizations (ACOs) to move towards accepting risk on a quicker basis, or get out of the program
- Given the importance of post-acute care to the success of Advanced APMs, 2019 will likely see increased use of preferred networks, clinical integration, and use of gain sharing and new payment relationships where risk is shared between upstream entities and post-acute care

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Occupancy and Census

- In skilled nursing, occupancy rates in Q2 2018 hit a record low of 81.7 percent
  - A large contributor to this dip is that, despite the large increase in Medicare Advantage enrollees, the Medicare Advantage mix has been flat
  - Medicare Advantage residents have a shorter average length of stay and a lower average daily rate than Fee for Service (FFS), skilled nursing providers will continue to see census and net operating income (NOI) pressures in 2019
- Senior housing providers have not fared much better in 2018, with a stagnant Q3 2018 occupancy average of 87.9 percent (down 0.8 percent from the same period in 2017)

Swift Action by Investors on Troubled Assets

- Capital continues to pour into the senior care sector by investors making a long-term play in anticipation of the silver tsunami's arrival in the future
  - Investors without operating experience in the senior care sector will look to forge partnerships with health care operators they expect will exercise stewardship in the operation of the business to ensure current and future returns never go at risk
- The mitigation of this scenario requires that the investor install monitoring safeguards that facilitate accurate and timely reporting of operating trends so that swift action and course-correcting plans may be developed before the operation spirals into crisis

Continued Significant Workforce Challenges

- Workforce challenges have grown substantially over the last several years and health care providers will continue to see increasing staffing challenges, workforce shortages, wage and benefit costs, and employment law enforcement
- Health care organizations will also need to ensure deliberate talent acquisition strategies and an engaged workforce to increase employee retention, allowing them to better drive the level of quality, customer satisfaction, and financial performance
- Partnerships with hospitals with more robust hiring practices and consistent staffing will accelerate

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More Complex Continuum and Network Development

- As the pressures of value-based payment meet the influx of capital into the senior care market, there will be innovative partnerships and cross-continuum service development
- Providers and investors will be looking beyond the physical walls of senior care to create partnerships with others like Medicare Advantage payors, pharmacies and retail giants, home health, technology, and other provider groups
- These innovative partnerships will reinvent the way the continuum works together to manage the quality and cost of senior care—not only for housing and health care, but for products and services as well

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Growth of Managed Care Models

- Alternative models to traditional Medicare FFS, such as Medicare Advantage, Institutional Special Needs Plans (ISNPs), and the Program of All-Inclusive Care for the Elderly (PACE), continue to grow in penetration and enrollment numbers
- Medicare Advantage—which has lower SNF utilization, SNF average lengths of stay, and reimbursement than Medicare FFS—now covers 33.9 percent of Medicare eligibles, an increase from 28.2 percent just five years ago
- The National PACE Association has a goal of increasing participant enrollment from nearly 50,000 nationally this year, to 200,000 by 2028

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Need to Better Manage Psychosocial Issues

- The social determinants of health are being better understood with population health
- While health systems and providers are addressing these non-medical factors as they work towards population health, hospitals continue to struggle with discharging patients who have complex psychosocial issues.
- As census continues to decline in skilled nursing and psychosocial issues climb, there will be an increase in discharge partnerships to transfer patients to post-acute settings to meet complex needs which have traditionally caused rapid discharge and readmission back to the acute-care hospital

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Post-Acute and Senior Care Asset Repurposing

- From 2010 to 2017, the senior population aged 65 years and older increased nearly 26 percent
  - During this same time, the average daily census at skilled nursing facilities declined over four percent due to declines in utilization, length of stay, payment reform, alternative options, and client preference
- Total licensed beds declined approximately one percent, and occupancy declined from 82 percent in 2010 to 79 percent in 2017
- SNFs will convert to senior housing alternatives, such as low-income or market rental apartments, specialized units like traumatic brain injury or mental health units, assisted living, or memory care assisted living

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Innovation from Rural Health

- Rural providers will face even bigger challenges than the broader senior care market is facing in terms of census, revenue, and staffing
- Rural SNFs that have not converted to assisted living will lead the charge towards innovation in revenue and service line development, new staffing models, and partnerships with other providers
- Rural providers will be forced to lead the way using technology—such as telehealth—and streamlined staffing models to survive
  - These innovations will ensure ongoing availability of hands-on care providers in markets with shrinking labor pools and aging demographics

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Aggressive Cash Management

- With the continuing growth of managed care contracts coupled with a challenging labor market, the skill sets available to manage this work will continue to be a rising factor in bottom line erosion for all facets of long-term care
  - Managed care organizations (MCOs) have seen their penetrations rise as high as nearly 68 percent in many markets, with Minnesota leading the way at 68.83 percent
- The ability to understand, negotiate, and execute on these contracts can be a drain on a typical nursing home community
  - The use of centralized models will allow providers to outsource risk and maintain focus on its main area of expertise—patient care.

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Genesis HealthCare ACO

Accountable Care Organization (ACO)

Genesis Eldercare Physician Services, LLC
GEPS Physician Group of Pennsylvania, P.C
GEPS Physician Group of New Jersey, P.C.
GEPS Physician Group of New Mexico PC
GPS Physician Group of Texas, PLLC
GEPS Physician Group of West Virginia, P.C.
GEPS Physician Group of North Carolina, P.C.
GEPS Physician Group of California, P.C.
GEPS Physician Group of Georgia, P.C.
GPS Physician Group of Rhode Island, P.C.

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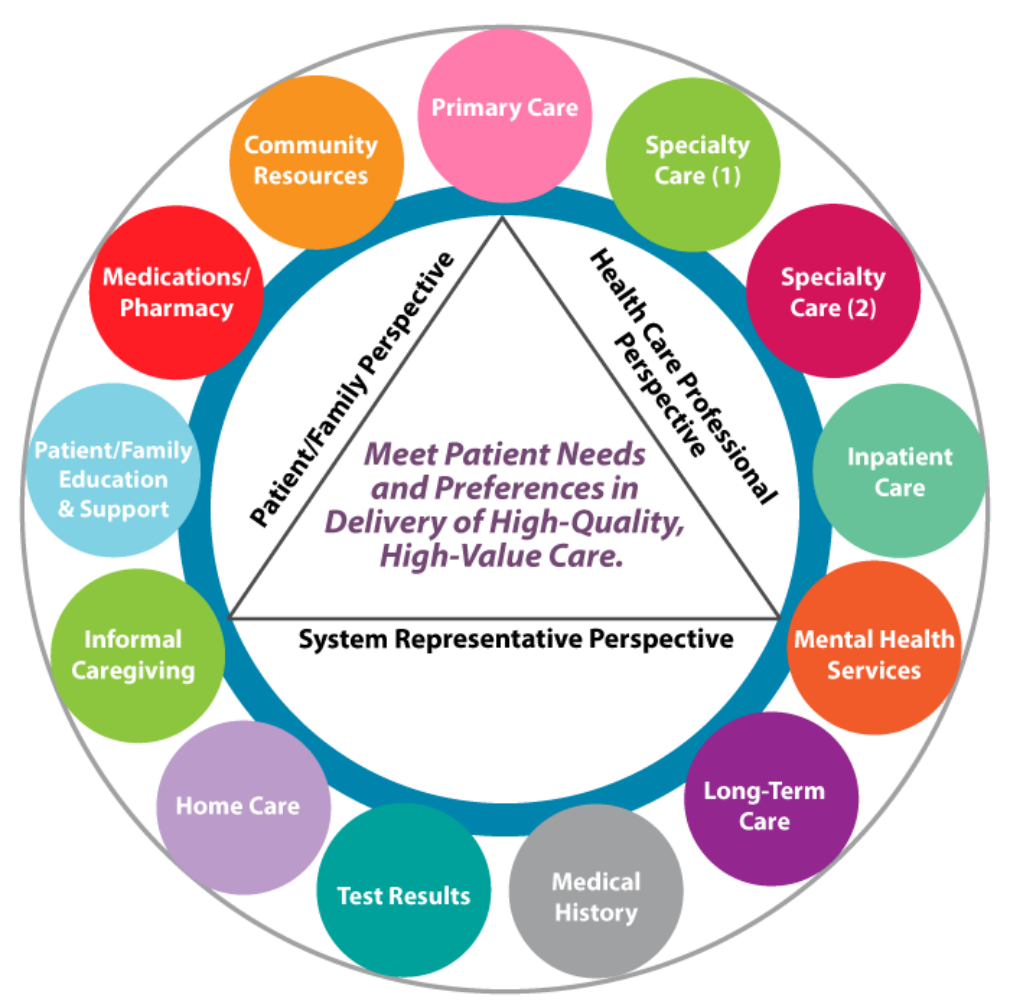
Coordination between primary care and specialty services



Vermont Information Technology Leaders

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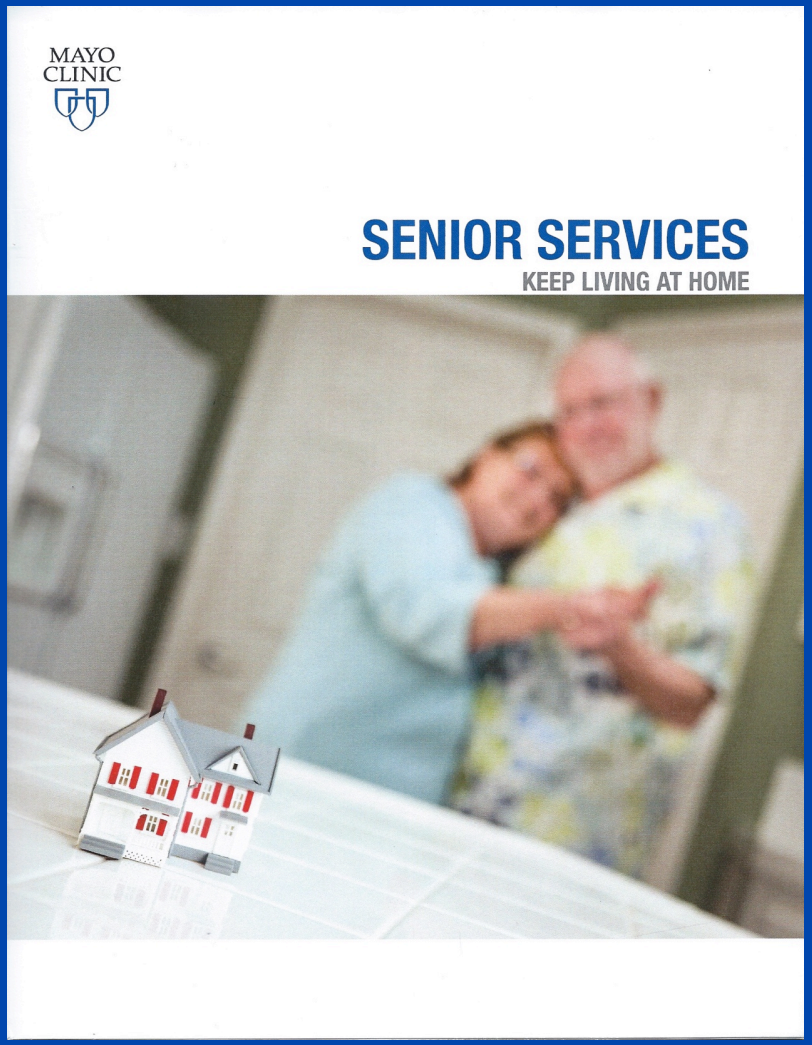
Linkages with community-based programs



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More hospital, home health and nursing home use

- Patients with AD had generally higher health care costs and higher risk of acute adverse outcomes than the control cohort
- Annual adjusted total health care costs per patient were approximately $1,418 greater for the AD cohort
- Patients with AD had an unadjusted fracture risk of 14.6% versus 6.2% in the matched cohort and accidental injury/falls risk of 27.4% versus 11.4%

Alzheimer's & Dementia 2008. 4(5):361-367.

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Hospitalizations and delirium

- For psychiatric services, subjects with a dementia diagnosis had significantly more outpatient visits (2.2 vs. 0.3, $p<0.001$) and significantly higher outpatient costs (US$124 vs. US$16, $p<0.001$) than comparison subjects
- For non-psychiatric services, subjects with a dementia diagnosis also had significantly more outpatient visits (34.4 vs. 31.6, $p<0.001$) and significantly higher outpatient costs (US$1754 vs. US$1322, $p<0.001$) than comparison subjects
- For all healthcare services, subjects with a dementia diagnosis had significantly more outpatient visits (36.7 vs. 32.0, $p<0.001$) and significantly higher outpatient costs (US$1878 vs. US$1338, $p<0.001$) than comparison subjects
- The total cost was about 2-fold greater for subjects with a dementia diagnosis than for comparison subjects (US$3997 vs. US$2409, $p<0.001$)

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PLOS One August 26, 2014 https://doi.org/10.1371/journal.pone.0105789

More care transitions per year

- Compared to subjects never diagnosed, older adults with prevalent or incident dementia had greater Medicare and Medicaid nursing facility use, greater hospital and home health use, more transitions in care per person year of follow-up, and more mean total transitions
- Among the subjects with dementia, 74.5% of transitions to nursing facilities were transfers from hospitals
- Among transitions from nursing facilities, the conditional probability was 41.0% for a return home without home health care, 10.7% for home health care, and 39.8% for a hospital transfer
- Among subjects with dementia with a ≤30-day rehospitalization, 45% had been discharged to nursing facilities from the index hospitalization
- At time of death, 46% of subjects with dementia were at home, 35% in the hospital, and 19% in a nursing facility

J Am Geriatr Soc. 2012 May; 60(5): 813–820.

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Re-hospitalization and discharge to nursing facility

- The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries
- The goals of the CCTP were to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program
- These programs are now being developed throughout the country as penalties exist for re-admissions to hospitals

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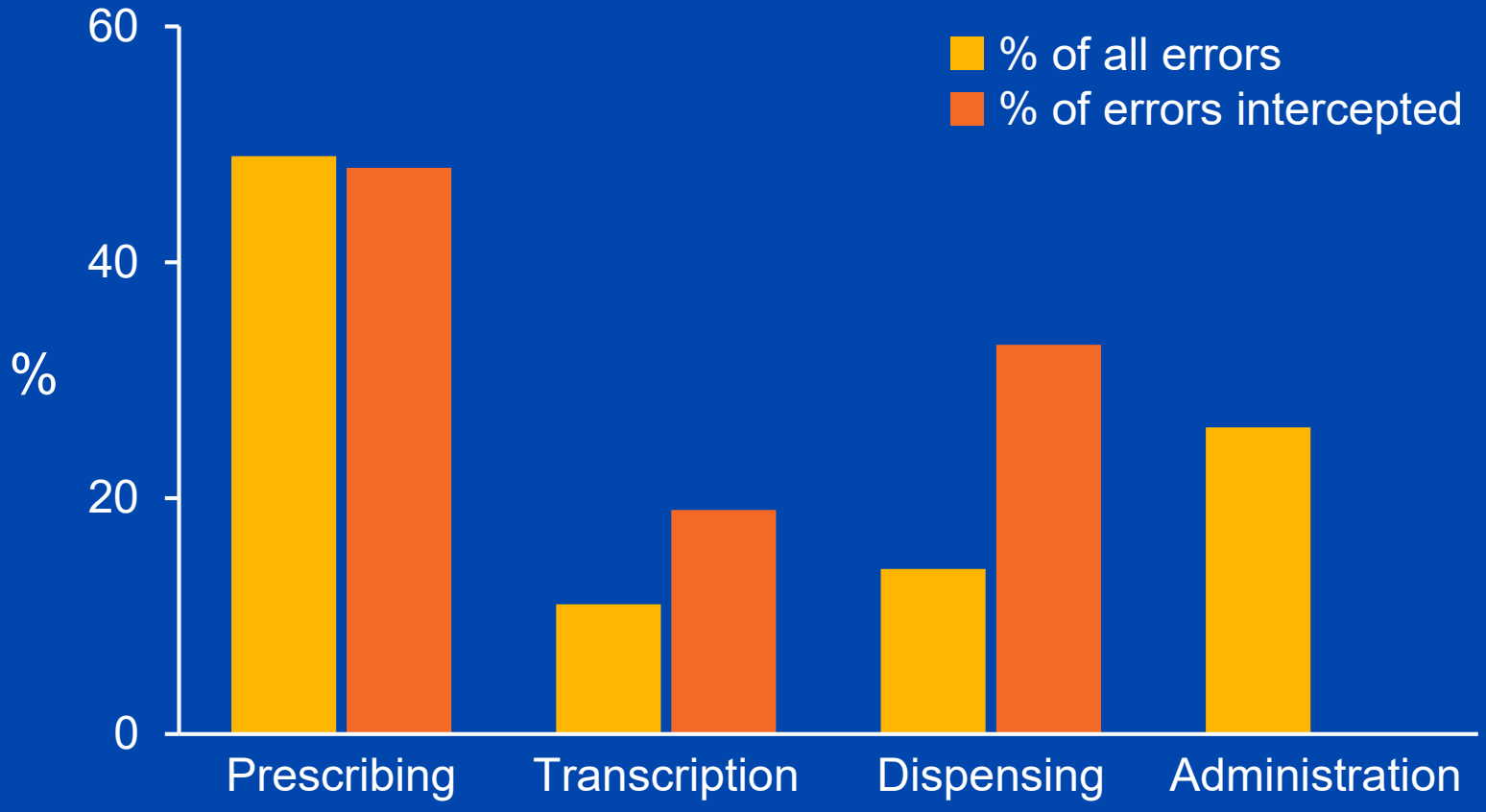
CPT 99483: Cognitive Assessment & Care Plan Services Required Service Elements

Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, ADLs and IADLs), including decision-making capacity
Use of standardized instruments for staging of dementia (FAST is often used)
Medication reconciliation and review for high-risk medications
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized screening instrument(s) (PHQ-9)
Evaluation of safety (e.g., home), including motor vehicle operation
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review, of an Advance Care Plan
Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation programs, adult day programs and support groups); shared with the patient and/or caregiver with initial education and support. (Easy to do with Epic's After Visit Summary)

Alzheimer's Association Toolkit

Service Element	Suggested Tools
Cognition-focused evaluation, including a pertinent history and examination of the patient	• Mini-Cog • Short MoCA • Key Elements of Cognition Evaluation
Functional assessment, including decision-making capacity	• Katz Index of Independence in Activities of Daily Living • Lawton-Brody Instrumental Activities of Daily Living Scale • Decision Making Capacity Assessment
Use of standardized instruments to stage dementia	• Questionnaire in Older Adults with Dementia • Dementia Severity Rating Scale (DSRS)
Medication reconciliation and review for high-risk medications, if applicable	• Medication List for Review
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments	• NPI-Q • BEHAV5+ • PHQ-2
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable	• Safety Assessment Guide and Checklist
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks	• Caregiver Profile Checklist • Stress Thermometer
Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference	• End of Life Checklist

Transitions pose increased risk for medical errors, higher costs, care inefficiencies



Field et al: Arch Intern Med 161:1629, 2001

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Safety as a career path

- Quality and safety are not the same thing
  - Quality measures are qualitative
  - Safety measures are quantatative
- Safety is not the art of the good catch nor the celebration of vigilance
- Safety is built into the processes of care and the engineering of best practices
- Safety training often run by engineers, physician astronauts and the VA
  - Best place to find a safety officer is in your hospital setting.

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History of Anesthesia Patient Safety

- A seminal publication from Harvard in 1978 described the use of the aviation-inspired critical incident analysis technique to understand the causes of anesthesia-related mishaps and injuries
- In 1984 the American Society of Anesthesiologists constituted a new standing committee on Safety and Risk Management, emphasizing the need to address the causes of patient injury
- Also in 1984 the president of the ASA and Harvard colleagues convened the International Symposium on the Prevention of Anesthesia Mortality and Morbidity, which constituted the first organized examination of what was soon to be known as “anesthesia patient safety”

International Anesthesiology Clinics
Issue: Volume 56(2), Spring 2018, p 65-93

Publication Type: [Review Articles]

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Medication Safety

- Simplification
  - 3 or 4 x a day reduced to 1 or 2 x a day
  - Elimination of PRN drugs
  - Switch from daily to weekly or from weekly to monthly
  - Consider using an infusion center (and its cost) for once a year rather than monthly or quarterly treatments
    - Osteoporosis
    - Anemia

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Simplification of the treatment program

- Each therapy needs a justification
- Redundancies and duplications can be eliminated
- Pharmacies can blister pack a week (or a month) worth of medications for easy identification and improved compliance
- Reductions in drug passes may be single biggest opportunity to reduce errors, reduce caregiver burden, save money and limit transitions of care

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Apply the technology of the day

To the Editor.— The transmission of medical orders and medication changes from the physician's office to the nursing home has been a time-consuming process in the provision of health care for the elderly. During the last year we implemented a program that uses facsimile (fax) machines to transmit physician orders to seven local nursing homes. We believe that this model has wide applicability for physicians with large nursing home practices.

Nursing Homes and Fax Machines
Eric G. Tangalos, Phyllis I. Freeman, Sherry L. Garne, Colleen P. Kosiak.
JAMA. 1990;264(6):693-694. doi:10.1001/jama.1990.03450060039017

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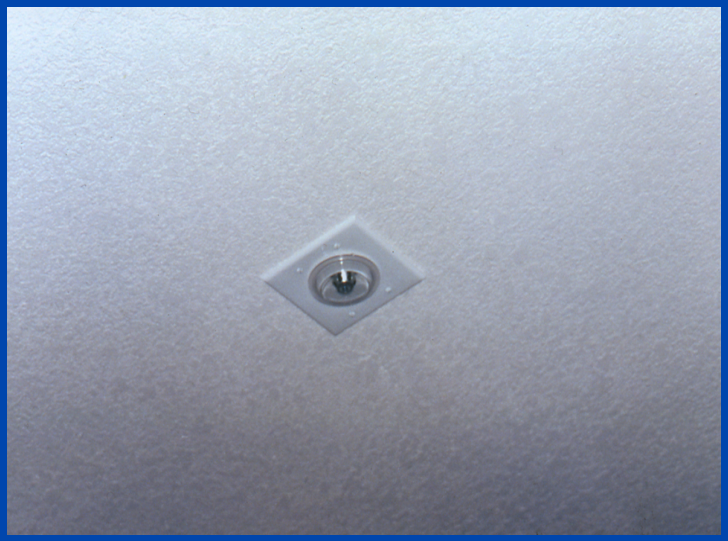
Passive sensors



- IR and RF
- Motion
- Load cells
- GPS
- Bar code
- GelPac


BECKY


LA LOVING

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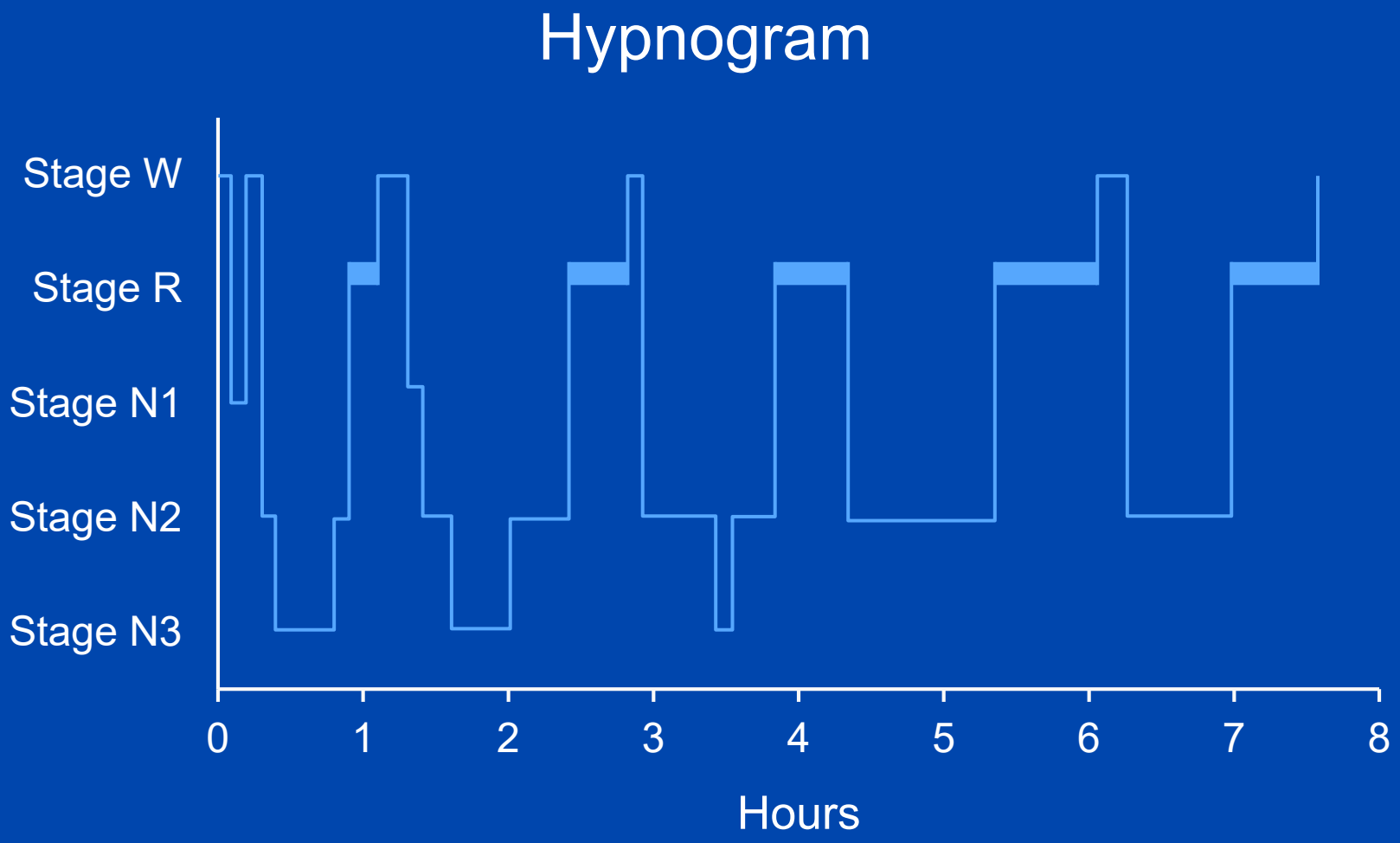
Normal Sleep

4-6 Cycles of a NREM-REM



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Precision medicine

- Precision medicine is a medical model that proposes the customization of healthcare, with medical decisions, treatments, practices, or products being tailored to the individual patient
- SCAR
  - HLA-B*5801 allele as a genetic marker for severe cutaneous adverse reactions caused by allopurinol
  - Allopurinol-SCAR is strongly associated with a genetic predisposition in Han Chinese
  - In particular, HLA-B*5801 allele is an important genetic risk factor for this life-threatening condition

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Population medicine

- Harvard Pilgrim Department of Population Medicine has defined population medicine as "the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated"
- Population health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group"

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Mayo ERA publications

- The Elders Risk Assessment Index, an Electronic Administrative Database–Derived Frailty Index, Can Identify Risk of Hip Fracture in a Cohort of Community-Dwelling Adults
- The Relationship Between Elder Risk Assessment Index Score and 30-Day Readmission from the Nursing Home
- Use of the elderly risk assessment (ERA) index to predict 2-year mortality and nursing home placement among community dwelling older adults

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Palliative Care: Nursing Home

- In a national survey of bereaved family caregivers of nursing home residents, the following results were reported
  - Between 32 percent and 24 percent of their loved ones that had experienced either pain or dyspnea, respectively, did not receive enough help
  - Almost 60 percent reported receiving inadequate emotional support during their loved ones' terminal illnesses
  - Only 42 percent rated their loved one's quality of life in the nursing home as excellent, which was the lowest rating of all health care settings
    - In contrast, 71 percent gave an excellent rating to care delivered at home with hospice services

Up to Date, October 2017
Gary S Winzelberg, MD, MPHLaura C Hanson, MD, MPH

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Palliative Care: Nursing Home

- Dementia as the primary problem in nursing home residents
  - Though many individuals are admitted to long-term care facilities due to the effects of cognitive impairment, the prevalence of dementia among residents in long-term care facilities is poorly reported
    - In one state survey, two-thirds of individuals in assisted living carried a diagnosis of dementia
  - In addition, the estimates on the prevalence dementia among nursing home residents range from 32 percent in the 2004 national nursing home survey to 50 percent of individuals admitted to nursing homes in another state survey
  - Caring for residents with dementia is perhaps the most challenging in terms of providing high quality palliative care as cognitive impairment complicates residents' ability to report symptoms and ultimately requires involvement of surrogate decision makers

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Palliative Care: Nursing Home

- Initiatives to improve palliative care in long-term care settings
  - There is limited availability of palliative care programs in United States nursing homes, and significant underutilization in those facilities with programs
  - There are few data to inform the implementation of interventions that may improve the quality of palliative care in long-term care settings but chief among them is ensuring greater access to hospice services
  - In the United States, this has already occurred with hospice enrollment increasing from 28 to 40 percent among nursing home residents between 2004 and 2009
  - A similar increase in hospice enrollment has been noted among patients with dementia

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Up to Date, October 2017
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The nursing home palliative care unit

- Mayo has a robust palliative care and homebound program
  - We can define patients at risk despite not having an ACO
- Bethany Samaritan nursing home has an unused floor with 22 certified skilled beds
  - Difficulty to staff
  - Census competition
- Mayo Hospitals are cost effective and profitable with a referred population of patients
  - We lose money on community patients who take up valuable bed space for chronic illness and repeat admissions
- Thus a new model of care staffed by Mayo in the nursing home to keep patients away from readmissions

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Think opportunistically

- What state chapter hosted the AMDA national meeting and when?
- Why are AMDA annual meetings held in March?
  - What ever happened to warm climate AMDA spring meetings?
- How did AMDA gain membership in the AMA House of Delegates?
- Who was Nick Owens and what did he do for AMDA?

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Think strategically

- AMDA's rapid growth
  - Began with OBRA '87
  - Continued with the 1990 fee schedule
    - One year before the RUC
      - RUC was established in 1991 by the American Medical Association (AMA) and medical specialist groups
      - In 2002, a RUC update of values raised concerns that the process, which was initiated by medical speciality groups, unfairly cut primary care physician pay.
- Accelerated with state involvement for the 1995 White House Conference on Aging

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Think synergistically

- In all that you do each activity should fit into a structure that builds on previous work and leads a path for your future
- When you become an expert in what you do, it takes less effort to become an expert in a similar activity
- Play on a global stage
  - There are often more rewards beyond your regular job
  - There are more avenues to pursue when some roads get blocked

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Doorway thoughts

- Open doors for others to walk through
- Paying it forward
  - “When you get to the top floor, don’t forget to send the elevator down for someone else”
- Execute the plan
- Money is like soap; the more you handle it, the faster it disappears

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1978

Phyllis Freeman, N.P.

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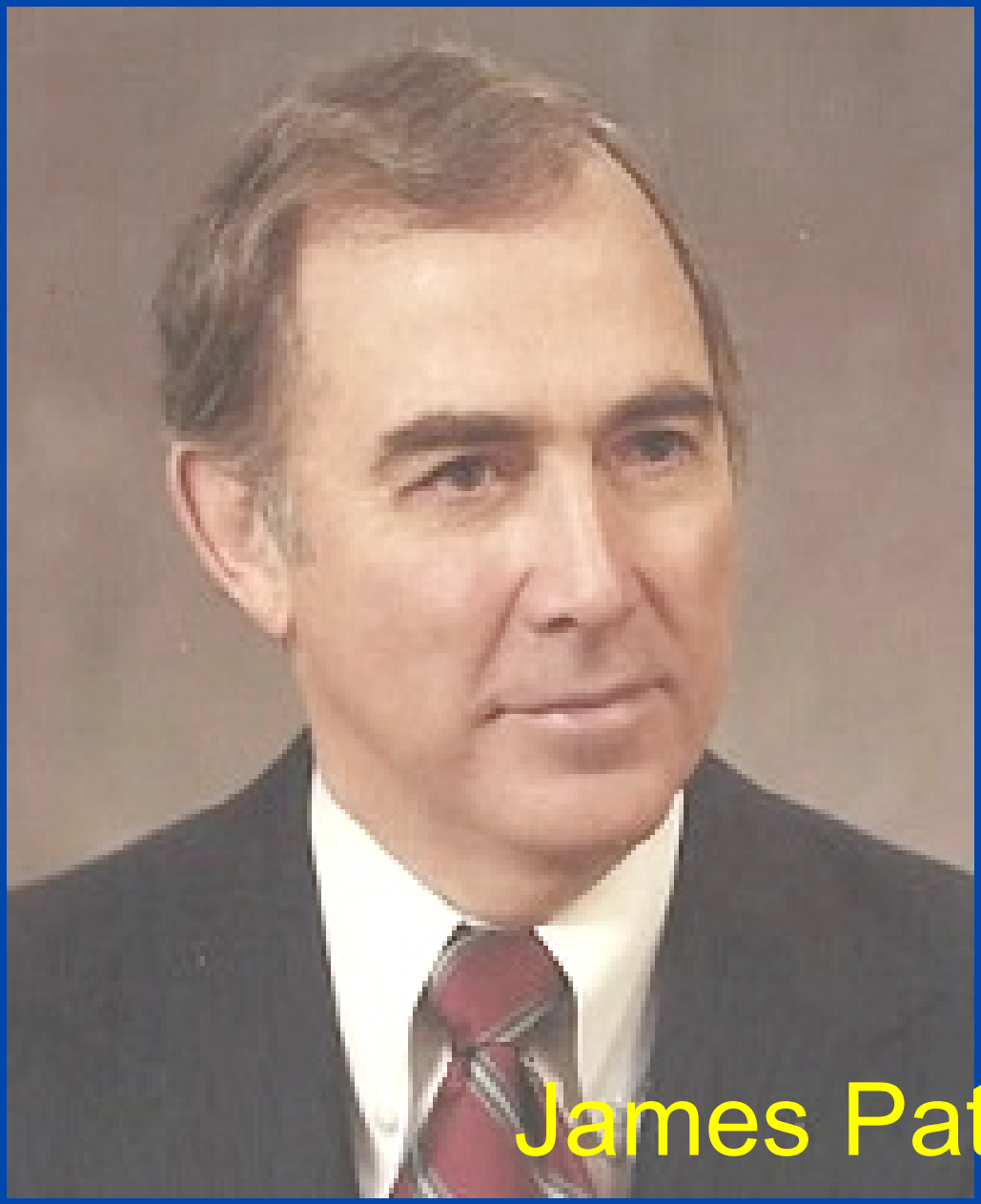

James Pattee, MD

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Questions & Comments

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