Medical Perspective of Duals

Friday May 21, 2021, Virtual Meeting

Presenters

- Dr. Steven Counsell, Medical Director, Division of Aging, Executive Director, GRACE Team Care Program, Professor of Medicine, IUSM
- Dr. Glenda Westmoreland, Director of Geriatrics Education, Indiana University Department of Medicine, Co-Director, IU Geriatrics Workforce Enhancement Program, Clinical Associate Professor of Medicine, IUSM
- Dawn E. Butler, Director, GRACE Training and Resource Center, Co-Director, IU Geriatrics Workforce Enhancement Program, IU Geriatrics, IUSM
- Dr. Kathleen Unroe, Scientist, IU Center for Aging Research, Associate Professor of Medicine, IUSM, Founder, Probari Inc.

Learning Topics

- Duals, D-SNPs, and Care Coordination Review
- Geriatrics and Age-Friendly Healthcare
- Challenges in Primary Care of Older Duals with Complex Needs
- Geriatric Resources for Assessment and Care of Elders (GRACE) model
- Optimistic Model
- Opportunities for Better Care and Better Outcomes

Agenda

1. Welcome and Meeting Purpose
2. Duals-Medical Perspective
3. Questions and Discussion

Summary of important facts from the presentation

Dr. Steven Counsell, Medical Director, Division of Aging

- There are 12 million Americans who are dually eligible for Medicare and Medicaid (Duals), and 230,000 of those individuals reside within Indiana. Nationally, 48% of Duals are part of a minority racial or ethnic group. Dually eligible individuals have a larger proportion of chronic illnesses, behavioral health conditions, disabilities, and functional limitations compared to those who are only on Medicare. This population also has a higher utilization rate of high-cost care. Medicare covers acute and post-acute care, primary and specialty care, as well as medications,

due to age or disability. Medicaid covers behavioral health services and LTSS, due to low income and assets. For those who are dually eligible, Medicare is the primary payor. Medicare and Medicaid are two distinct insurance programs, typically fragmented and the care provided is poorly coordinated.

- In Indiana, of the 230,000 dually eligible individuals, 30% are enrolled in a Medicare Advantage Plan, called a Dual-Special Needs Plan (D-SNP). Each plan is required to outline a specific Model of Care, which includes care coordination. This plan outlines how staff is structured, how health risk is assessed, how individualized care plans are developed through an interdisciplinary care team, and how care transitions are coordinated. Medicare drives the individual's clinical care, care management, and coordination when part of a D-SNP.
- Care Coordination benefits individuals who would be considered the typical Aged and Disabled Waiver participant. This includes older adults with limited income and assets, who need help with 3+ ADLs, and who choose to live at home instead of residing in a nursing facility. Further considerations include multiple chronic illnesses, multiple medications, and geriatric conditions including dementia, as 1/3 of Waiver participants have dementia. These individuals often have multiple physicians, and healthcare providers may have limited geriatrics expertise, along with communication and coordination of care challenges.
- Geriatrics healthcare professionals strive to optimize quality of life and independence while using an interdisciplinary team approach. These teams include nursing and social workers, to integrate medical and social care with a focus on the social determinants of health. Services are provided in multiple settings, such as hospitals, outpatient, nursing facility, rehab, home visit, and mental health settings. These professionals specialize in recognizing normal aging vs. disease, geriatric syndromes, care transitions, multiple chronic illnesses with functional limitations, primary care, and consultation.
- An Age-Friendly Health System initiative was developed by the John A. Hartford Foundation, with the Institute for Healthcare Improvement (IHI). This initiative uses a person-centered approach to maintain the health of older adults to improve health outcomes and prevent avoidable harm. A framework called the 4Ms has been employed to ensure reliable, evidence-based care for older adults in all settings. The 4Ms include What Matters, Medications, Mentation, and Mobility.

Dr. Glenda Westmoreland, Director of Geriatrics Education, Department of Medicine

- Case presentation of Mr. and Mrs. Smith, fictionalized primary care patients of Dr. Westmoreland's at the Eskenazi Health Center for Senior Health. These individuals are both on the A&D Waiver program and are cross-caregivers. They both have several chronic conditions, but it is highlighted that Mr. Smith has been diagnosed with Alzheimer's disease, which he does not endorse. Mrs. Smith has had a recent heart attack, which happened at home, but led to a 3-day hospitalization, followed by a subacute rehabilitation stay in a nursing facility. After transitioning home, Mrs. Smith saw Dr. Westmoreland for a primary care visit.
- An interdisciplinary team of social work, nursing, and a physician allows for complex needs to be addressed beyond what traditional primary care can offer. Social work assesses the patient's mood, arranges for home care, and coordinates with the CICOA Waiver Care Manager. Nursing reviews medications, assesses the patient's understanding of the care plan, and provides patient

education. The physician assesses current medical issues, mobility, mentation, and medications, along with what matters, and the need for additional services. Finally, the physician coordinates care with social work and nursing during a huddle.

- This case highlights an interdisciplinary visit utilizing the 4M framework, addressing what matters most, mobility, mentation, and medication. Mrs. Smith returned home with a loss of mobility, and she now uses a wheelchair. The loss of mobility has resulted in a decline in mood, and she also experienced delirium in the hospital. Her medications were brought to the visit, which included medications that were taken prior to the hospitalization, medications that she was discharged from the hospital with, and medications that were given while at the nursing facility. These medications needed to be sorted, since her husband was giving them all to her to take. What matters to the Smiths is to stay in their home, together, and living with independence. The Smiths' healthcare was directed with this framework in mind.

Dawn Butler, Director, GRACE Training and Resource Center

- One of the key underpinnings of GRACE is that primary care physicians have limited time and resources to provide comprehensive care to older patients. GRACE stands for Geriatric Resources for Assessment and Care of Elders, and the first two letters are significant because this model is geriatric focused, while bringing resources to the table. The first step is to have a nurse practitioner (NP) and social worker (SW) come into the home to complete a geriatric focused assessment. Coming into the home allows the team to get a sense of how the individual is doing, and to observe what is truly going on in their environment. The NP completes a focused geriatric assessment, including a geriatric review of systems, and finds and documents all the medications that are being taken. The SW completes a social history, a caregiver assessment, home safety evaluation, a cognitive assessment, along with a depression screening. The team focuses on finding out what matters most, because this, along with the assessment results, drive the individualized care plan using GRACE protocols. The NP and SW meet with an interdisciplinary team weekly, which includes a geriatrician, pharmacist, and mental health liaison. The NP and SW connect with the individual's primary care provider to share their findings and discuss the implementation of the care plan. The care plan is then implemented during another visit with the individual, and ongoing care management and caregiver support are provided.
- Transitional care is provided for individuals who are currently receiving care, although individuals not receiving care could be enrolled into the program. When an individual who is already receiving care enters the hospital or emergency room, the team is alerted by the health system. This enables the GRACE team to communicate the individual's baseline status and care plan, as well as collaborate in planning the transition. Once the individual has transitioned home, a targeted transition visit is performed to provide support to the participant and family/caregiver. Medications are sorted and a new medication list is provided, and post-discharge arrangements are implemented. The PCP is then informed of the transition, and a follow-up visit is scheduled with them. The GRACE team then reviews all individuals who have transitioned in a team conference to discuss any change in condition and to also determine if any quality improvement measures are to be taken.
- There are 12 GRACE protocols, including advance planning, health maintenance, and medication management. These three protocols are activated with all clients, and the remaining nine are

activated as needed. The remaining protocols include difficulty walking/falls, depression, dementia, caregiver burden, chronic pain, malnutrition/weight loss, urinary incontinence, visual impairment, and hearing impairment. These protocols are designed to complement and support primary care and the management of other conditions, such as diabetes and high blood pressure.

- A large, randomized trial with over 950 individuals was conducted, and the study determined that everybody enrolled benefitted from the program. Individuals in a high-risk group had fewer emergency department visits and hospitalizations, as well as reduced acute care, which offset program costs. ACOVE Quality Indicators of general health care and geriatric conditions showed better performance, and an enhanced quality of life was reported among individuals in general health, vitality, social function, and mental health.

Dr. Kathleen Unroe, Scientist, IU Center for Aging Research

- The OPTIMISTIC project was the Indiana site of a national CMS funded demonstration project. The initial phase from 2012-2016 tested a clinical model to reduce the frequency of avoidable hospital admission and readmissions among long stay, dual eligible nursing facility residents. The project worked with 19 facilities, each with an average census of 100 residents. The model was built by embedding an RN in each facility, supported by a group of NPs. The second phase, which just wrapped up, expanded to 40 nursing facilities to test a Medicare payment model. The clinical model was supported in the 16 original facilities for all eight years of the project.
- The project was successful, as OPTIMISTIC facilities reduced the probability of all-cause hospitalizations by 19.3% annually. The probability of potentially avoidable hospitalizations was reduced by 32.6% annually. This was accompanied by savings to Medicare, showing a reduction of $1,589 per resident per year in total Medicare expenditures. OPTIMISTIC had a total spending reduction of nearly $13.5 million, and a net savings when including the cost of the grant of over $3.4 million.
- The clinical model intends to enhance, augment, and support the clinical care team in facilities by embedding nurses in facilities to respond to an acute change in condition. When an episode of care was identified, the nurse would be involved in the initial assessment and change in condition, as well as the follow-up care. Quality improvement efforts also integrated the nurses and centered around root cause analysis of transfers. Advance care planning to promote person-centered care in facilities was performed through trained facilitators. Nurse practitioners were in facilities around 1 day per week, and they performed detailed transition visits as well as supported the RN staff in education efforts.
- Stakeholder interviews were performed, including with nursing home staff and leaders, primary care providers, family members, and OPTIMISTIC clinical staff. Strengths were identified, including an interdisciplinary approach to reducing hospitalizations, as well as advance care planning. Involvement in day-to-day clinical care distinguished this model as one of the more successful models compared to the models that did not have significant findings.
- The OPTIMISTIC model lives on as Probari, a scalable, virtual care model. The nurses cover multiple facilities, relying on electronic medical record data, as well as clear communication with nursing facility staff. Clinical reviews of transfers and new admissions are performed, as well as identifying and monitoring patients at risk to breakdowns of care through trend data. The staff

also tries to anticipate issues, while promoting advance care planning and person-centered care. Enhancing, supporting, and extending the capacity of the frontline providers in the building by making clinical recommendations, providing training and support to enhance the overall quality of care in facilities.

Dr. Steven Counsell, Medical Director, Division of Aging

- At the State, meetings are being held with Medicare D-SNPs regarding the contracts for information sharing and model of care and how D-SNPs can be aligned with mLTSS. There are opportunities to integrate the benefits under both Medicare and Medicaid. The health plans under managed care are responsible for the quality of care and the costs. The value added by D-SNPs and eventually, Medicaid mLTSS contracts are made possible through requirements, which could include embedding Age-Friendly Health Systems and the 4Ms. This could be accomplished by identifying evidence-based models of care and interventions that will improve care to impact a larger population. Care coordination between medical care and social services is to be emphasized, to keep the focus on the individual and what matters to them.

Questions/Answers

Alzheimer's Association: Thanks to each of the incredible speakers today. We are so fortunate to have national leaders in these innovative, evidence-based programs here in Indiana. Such great expertise shared today!

Indiana Association of Area Agencies on Aging: Promising results are coming out of the Geriatrics Workforce Enhancement Program (GWEP) in University of Southern Indiana (USI) as well. Area Associations on Aging (AAAs) embed in the health care setting –coordinating between clinical care and social services.

Thrive Alliance: Coordinating medical records between providers is still a big challenge. As well as making sure the individual gets copies of instructions like medication lists as they transition.

> **FSSA:** We couldn't agree more. Integrated data as we have discussed is integral to the success of this program. We are asking, "how do we get better data integration with the Electronic Medical Records (EMR) as well, both from a lot of our facilities, our nursing homes, but also from our D-SNPS?" One of the requirements that will be coming up in the 2022 D-SNPs is for them to be a part of Indiana Health Information Exchange (IHIE) as well so we have better visibility of the clinical care-medications, prescriptions, admissions, diagnosis, and transfers across facilities and care providers.

FSSA: Thank you Dr. Counsell and all the presenters for such a great discussion of the underlying concepts and practices that drive success in this space. This really helps tie together many of the discussions we have had around Duals!

CICOA: Thanks, great presentation.

Closing comments

Dr. Dan Rusyniak, FSSA

To echo a couple of comments, these were fantastic presentations. From experience as an Emergency Medicine physician at Eskenazi –it's not just primary care that is happy to see that the GRACE team is involved –it's a relief to know that a patient will have that coordinated and integrated care. Medication management is one of the biggest challenges to see in the aging population, along with deprescribing medications. The IU Center for Aging Research has been on the forefront of de-prescribing research, as well as identifying which medications should not be prescribed to older individuals. Would like to publicly thank to Dr. Unroe and Probari who have done innovative work with OPTIMISTIC and were integral in helping the State with the COVID response. The flexibility of their team and their willingness to do almost anything to reduce outbreaks and benefit the care of individuals in nursing homes spoke volumes to the work they do with OPTIMISTIC. Thank you to everyone who presented and who attended today's talk.

Follow-up

Please contact backhome.indiana@fssa.in.gov with any additional questions.

Stakeholder Attendees

Ambre Marr, AARP Indiana; Beth Skinner, CICOA; Cara Veale, Indiana Rural Health Association; Dawn Butler, Indiana University School of Medicine, IU Geriatrics; Elaine Sawyer, ADvancing States; Elizabeth Eichhorn, IHCA; Ellen Burton, University of Indiana; Eric Essley, LeadingAge Indiana; Glenda Westmoreland, IUSM; Jim Smith, Probari Systems; Kathleen Unroe, IU; Kelli Tungate, Caregiver Homes of Indiana; Kim Dodson, the Arc of Indiana; Dristen LaEace, I4A; Mark Lindenlaub, Thrive Alliance; Michael Kaufmann, IDHS; Natalie Sutton, Alzheimer's Association; Russell Evans, IU Health Physicians/Probari Systems; Sarah Waddle, AARP Indiana; Sherri Hampton, ASC; Teresa Lorenz, Thrive Alliance; Terry Cole, IHA; Terry Miller, Hoosier Owners and Providers for the Elderly

FSSA Attendees

Amy Gilbert, Amy Rapp, Andrew Bean, Brenda Buroker, Cathleen Nine-Altevogt, Daniel Rusyniak, Darcy Tower, Elizabeth Peyton, Emily Cook, Erica Ng, Erin Wright, Jesse Wyatt, Kathy Leonard, Kim Opsahl, Lucy Morrell, Lynn Clough, Meredith Edwards, Michael Gargano, Mindy Flowers, Sarah Renner, Shannon Effler, Steve Counsell, Tim McFarlane