

Protecting Medically Vulnerable Older Americans

The New America Foundation
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Vulnerability in Old Age

Poverty

Abuse

Chronic health conditions

→ Discomfort, disability, dependency,
depression, dementia, death

Reducing Medical Vulnerability

Prevention of disease

Health care for people who have disease

Patient-centered, evidence-based, comprehensive,
coordinated, and affordable

Chronic Care in America

Provider-centric

Idiosyncratic

Fragmented

Uncoordinated

Expensive

Value of Chronic Care

Value = Quality / Cost

American chronic care:

Quality is low: 6th of 6 developed nations

Cost is high: 2-3 times greater than the other five developed nations

K. Davis, Commonwealth Report 2007

American Innovations in Chronic Care

Alternative models for providing chronic care

Attempt to narrow the “quality chasm”

Attempt to protect the medically vulnerable

Attempt to improve the efficiency of resource
use

Goals

Describe recent innovations in chronic care that have shown promising results

Discuss the promising models' "diffusability"

Suggest some policy options for promoting the adoption of effective, diffusable models

Method

Literature search

Tabulation of evidence for promising models

Classification of the strength of the evidence

Consensus ratings of models' diffusability

Discussion of policy options

Results

15 successful models:

Categorized according to setting of care

Community, transitional, inpatient

Presented according to their effects

on health, quality of care, efficiency of care

Rated according to their diffusability
potential

Details in tables in report

Potentially Diffusable Successful Models

| Model | Improves health care quality or outcomes | Improves health care efficiency | Diffusability score (6-30) |
|--|--|-------------------------------------|----------------------------|
| APN-physician team (for dementia pts) | 1 cluster RCT | None | 19 |
| IDT (for CHF) | 1 meta-analysis 2 reviews | 1 meta-analysis 2 reviews | 25 |
| Guided Care (for multi-morbid pts) | 1 cluster RCT 1 controlled trial | 1 cluster RCT 1 controlled trial | 23 |
| Care mgmt (for CHF) | 3 RCTs | 3 RCTs | 21 |
| Pharmaceutical care | 4 RCTs | 2 RCTs | 19 |
| Self-management training | 1 meta-analysis 9 RCTs | 4 RCTs | 24 |
| Proactive rehabilitation | 4 RCTs | 2 RCTs | 19 |
| Caregiver support/education | 1 meta-analyses 1 RCT | 2 meta-analyses 2 RCTs | 19 |

Potentially Diffusible Successful Models

| Model | Improves health care quality or outcomes | Improves health care efficiency | Diffusability score (6-30) |
|---|--|---------------------------------|----------------------------|
| Transitional care | 1 meta-analysis 1 RCT | 1 meta-analysis 2 RCTs | 20 |
| APN-physician dyads (for NH residents) | 3 quasi-experimental studies | 3 quasi-experimental studies | 21 |

Policy Options for Reducing Medical Vulnerability

Fee-for-service Medicare

Care mgmt and shared savings payments to “medical homes” (MMHD laws of 2006, 2008)

Payments to pharmacists, nurses and rehab therapists who supplement primary care

Payments to organizations that provide nurse-based transitional care

Policy Options for Reducing Medical Vulnerability

Special Needs Plans (SNPs)

Extend contracts with NH SNPs that use APN-physician dyads to provide care

Medicare Advantage (MA) plans

Adjust CMS's per capita payments to reflect beneficiaries' ratings of the quality of their care

Administration on Aging – fund AAAs to provide:

Self-management courses

Caregiver education/support

Counseling in selecting health plans and EOL options

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