# Chapter 1
# Geriatricians Involvement in Healthcare Changes

**James S. Powers**

## Introduction

Physicians have traditionally strived to improve healthcare quality and continually develop new models of care. As innovators and leaders in the provision of healthcare, it is imperative that they understand the complex relationships between quality, efficiency, and value which are driving US healthcare changes in an unprecedented manner. The continuing rise in cost of US healthcare is unsustainable, making price and quality transparency the new rules of engagement.

Geographic variations in spending, healthcare access, and population health outcomes all reflect decisions contributed at least in part, by physicians. Physicians understand what is best for the patient and are aware of clinical realities. Healthcare system shifts from producer-driven to patient-centered outcome drivers demand physician involvement, and the time is now.

The Affordable Care Act has created a critical opportunity to contribute to increasing the value of healthcare services to all citizens. It is appropriate that physicians be among the leaders in promoting models of care. Geriatricians, especially, care for the sickest, most vulnerable, and most costly of the population. Geriatrician-led models are the historic innovations of many care processes shown to improve care. This is extremely relevant to healthcare changes. Geriatricians have a vast knowledge about caring for older people. They also have demonstrated an extraordinary and sustained commitment to improving the quality of life for older people. This value-added input is not clearly recognized by physician peers or healthcare organizations.

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Geriatric models of care include many approaches to care that are proven to be more effective, when appropriately targeted and applied, in treating older people. These include access, design, and outcome assessments in primary care settings, disease state management, hospital and post-acute care settings. These models demonstrate maintenance of function, cost avoidance, and reduced complications for selected frail elderly populations. They provide solutions benefitting older adults in proven and cost-effective ways that enhance quality throughout the healthcare system.

Acute Care for Elderly (ACE) Units provide interdisciplinary care, comprehensive review, and an environment of care conducive to early rehabilitation and patient-centered care, improving function and reducing iatrogenic and hospital acquired conditions [1]. These geriatric laboratories, present since the 1970s remain few in number nationally.

Geriatric Resources for Assessing Care for Elders (GRACE) team care, is a recent cost-effective team care model that improves the health of frail older adults by working with patients in their homes and communities to manage health problems, track changing care needs, and leverage social services. In the GRACE model, interdisciplinary teams guided by care protocols, improve outcomes. Increases in preventive and chronic care are offset by reduced acute care costs [2].

The Program for All-inclusive Care for Elderly (PACE) provides integrated acute medical care and long term care services to frail seniors. PACE provides a community-based alternative to nursing home care when nursing home placement seems necessary. PACE uses blended Medicare and Medicaid financing to provide care, and reduces mortality and improves function [3]. Present since the 1970s, the costs of PACE home based long term care are offset by avoidance of nursing home costs.

Assessing Care of Vulnerable Elders (ACOVE) is a series of evidence-based best practices for 26 conditions affecting frail elders [4] developed by collaboration between the American Geriatrics Society and the Rand Corporation. ACOVE addresses promotion of hospital safety for vulnerable elders, reducing hospital acquired conditions, IDT (interdisciplinary team) care, assessment of delirium in hospitalized patients, setting patient-specific goals for blood pressure (avoiding hypotension) and identifying and addressing risk factors for falls and decubiti.

Additional disease state innovations include development of best practices for medication safety and identifying potentially inappropriate medications (PIMS) [5], best practice recommendations for diabetes management [6], especially documenting the risks of hypoglycemia, and developing a clinical algorithm for patients with multiple co-morbidities [7].

Transitions of care programs for home care following hospitalization utilizing advance practice nurse-directed discharge planning and follow-up protocols have shown promise in reducing early repeat hospitalizations [8]. Similarly, the Coleman Care Transitions Program, a patient-centered self-management program coordinated by a health coach, has also reduced repeat hospitalizations [9]. INTERACT is a nursing home quality improvement intervention providing tools and strategies to assist nursing home staff in the early identification, assessment, and communication

regarding changes in resident status [10]. The improved communication and hand-offs between hospital and nursing home, appears to prevent avoidable re-hospitalizations. These innovative ideas are the basis of many of the new models of care encouraged by CMS and are centered around patient-specific goals, quality, and safety, reflecting cost avoidance on other components of the healthcare system.

Nurses Improving the Care of HealthSystem Elders (NICHE) is dedicated to the principle that all older adults be given sensitive and exemplary care. The program began in 1981 and is now operating in 450 US hospitals. NICHE helps participating hospitals build nursing leadership capabilities to enact system-level changes targeting the unique needs of older adults and put evidence-based knowledge into practice. NICHE tools exert important influences over care provided to older adult patients by increasing the organizational support for geriatric nursing [11].

A hospital at home (admission avoidance) program seeks to provide hospital-level care for selected patients in the patient's home. Operating as an enhanced interdisciplinary team home-care program, this model shows promise of achieving hospital quality standards with shorter lengths of stay. There are also suggestions of reduced complications in addition to increased family and patient satisfaction [12].

## What Is Driving Healthcare Changes?

Healthcare absorbs an increasing proportion of government and private sector spending without proportional benefits healthcare status and outcomes. According to the Budget of the US Government, healthcare equates to approximately 19 % of overall spending, exceeding both education and defense spending. Yet the US spends more per capita on healthcare than any other nation, including a 70 % increase in per-beneficiary Medicare spending between 2000 and 2012 and total healthcare expenditures continue to rise (Fig. 1.1). At the same time the US falls at

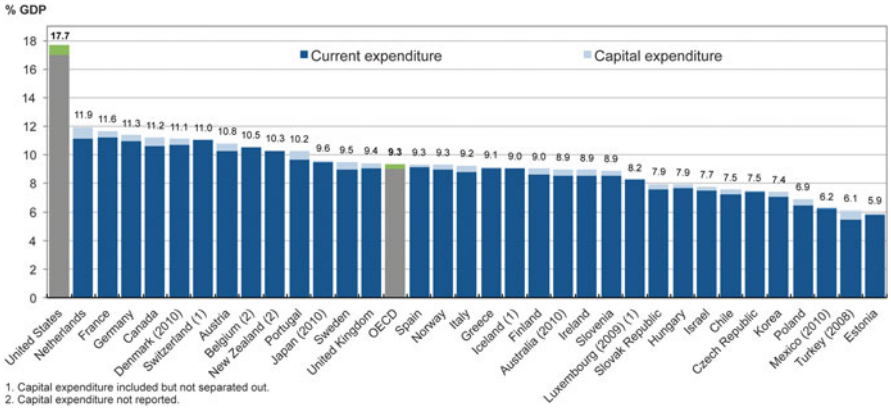


**Fig. 1.1** Total health expenditure per capita, $US PPP (OECD (2013), *OECD Health Statistics 2013*, OECD Publishing, Paris. http://dx.doi.org/10.1787/health-data-en)

37 overall for health outcomes, trailing many nations in infant mortality, life expectancy, patient safety, healthcare access, disease management and measures of health disparities [13].

Healthcare costs have risen at an unsustainable rate, and there are serious mismatches between cost, outcomes, and distribution of health resources in the US. This curious combination of high cost and poor outcomes has engendered much criticism and concern for inefficiency, waste, and profiteering incentivized by a fee for service and procedure-based reimbursement system. Major changes in healthcare financing and delivery are inevitable, with an emphasis on reducing overhead expenses and costs associated with little or no outcome benefit. The message is clear, the time is now for physicians to engage in the process of change, not stubbornly grasping at long-standing silos of specialty care, but real involvement to create a seamless flow of coordinated care – at the starting gate.

Physicians control 80 % of healthcare spending, including the location where patients are seen, laboratory and diagnostic testing, and treatment and further referrals. While physicians are not the only ones responsible for controlling healthcare costs, real cost containment requires that all relevant stakeholders are mobilized to ensure that patient centered care is at the core of any changes. Physicians cannot be absent, indeed they must lead these changes. As collaborators and innovators, geriatricians are a natural force in leading healthcare change. Indeed all physicians now have a unique opportunity to serve as leaders. Furthermore, because of their credibility, the population looks to them for direction in healthcare matters.

The triple aim of the Institute for Healthcare Improvement is to improve the patient's experience of care, improve the health of the population, and reduce the per-capita cost of health care. This focus on quality, efficiency, and value is forcing health systems to pay attention to older, vulnerable patients because they consume disproportionate resources. The Agency for Healthcare Research and Quality [14] reported that approximately 50 % of US healthcare expenditures are attributed to 5 % of patients [14]. CMS estimates that 70 % healthcare costs are related to chronic illness, and the Medicare population utilizes 32 % of resources in the last 2 months of life. In 2009 the Medical Expenditure Panel survey found that the sickest 10 % of patients accounted for 65 % of all healthcare expenses in the United States. Moreover, there is great disparity in healthcare outcomes that is not explained by cost. Geographic variation in healthcare costs in the Medicare fee for service population has fueled the perception of an inefficient US healthcare system which lacks transparency (Fig. 1.2). Elucidating the causes of geographic variation and comparing the effects of new models of care on usual costs and processes of care are important priorities for comparative effectiveness research. An Institute of medicine report suggests that 73 % of the variation is in post-acute care and 27 % inpatient care [15]. The reality of mal-distribution of resources, cost, quality, and outcomes his driving process standardization, more organized and coordinated systems focusing on cost consciousness in medical decisions, as well as greater price and quality transparency.

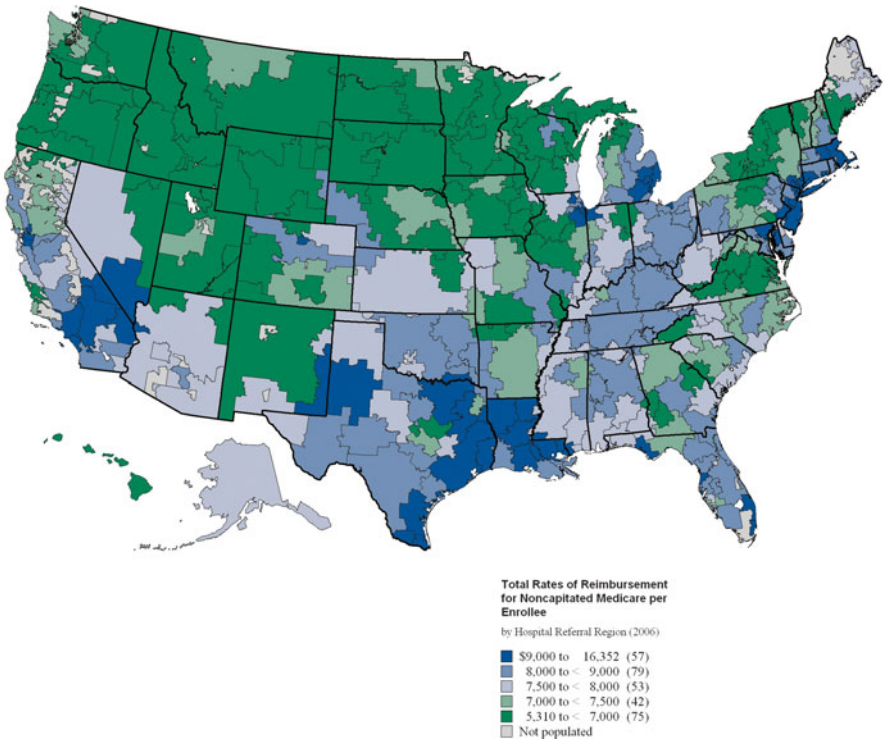


**Fig. 1.2** National variation in medicare spending (Fisher ES, Goodman DC, Skinner JS, Bronner KK. Health care spending, quality and outcomes. Hanover, NH: Trustees of Dartmouth College, February 27, 2009. http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf)

Globally the population of older people is growing rapidly. According to the UN World Population Prospectus, the US population over age 65, currently at 13 %, will make up 20 % of the population by 2040 and is projected to stabilize thereafter (Fig. 1.3). Due to these population dynamics, support for Medicare and Social Security rests on fewer taxpayers. Currently there are 2.9 workers per retiree and this is ratio is projected to be 2:1 in 2030, with future projections falling to 1:1 making the current structure financially unsustainable. Medicare Trust Fund, which covers hospitalization, will begin to decline by 2018 with depletion by 2026 according to the latest trustee report (Fig. 1.4). These realities are forcing a re-assessment of the US healthcare system and are major drivers of the Affordable Care Act of 2010.

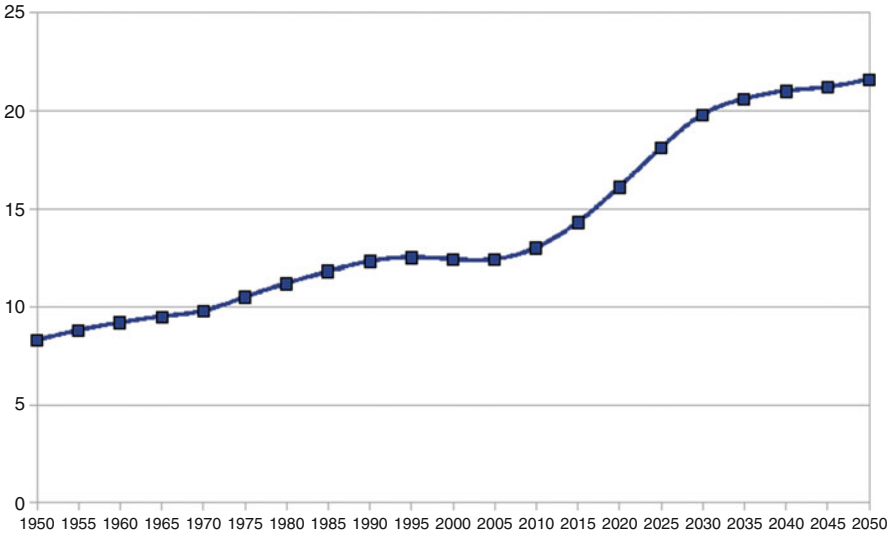


**Fig. 1.3** Percentage of US population over age 65, 1950-2052 (Source: UN World Population Prospectus 2008. *Creative Common Attribution 3.0 Unported License*)

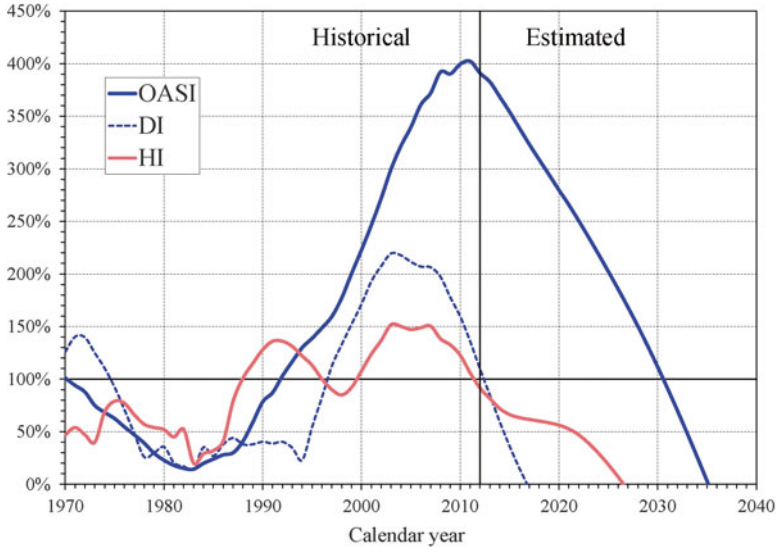


**Fig. 1.4** OASI (Social Security), DI, (Disability) and HI (Medicare) Trust Fund Ratios [*Asset reserves as a percentage of annual cost*] (http://www.ssa.gov/oact/trsum/. Accessed 22 Apr 2014)

## Healthcare Innovation

There are several ways to address increased costs to Medicare from this growing elderly population: cost controls, reduced benefits, or increased premiums. Naturally, neither of these approaches has any political momentum. Raising the eligibility age, increasing the payroll tax, or tying benefits to income level all adversely affect different segments of the population. There is therefore a major focus on controlling costs and improving efficiency. The US has about a 10 year window to reign-in runaway costs through improved care delivery, elimination of waste, and improved healthcare outcomes, and expanding access to preventive and primary care. Value-based purchasing, tying provider reimbursement to outcomes representing real value to patients, is a powerful new force designed to change provider incentives and leverage the healthcare delivery system to sustain change over time. This change in incentives will require widespread adoption by all payers and utilization of quality improvement teams in all healthcare settings. Performance on outcomes measures may negatively impact hospitals that care for more disadvantaged patients.

New models of care with varying degrees of risk will be required for individual and provider organizations to take advantage of these incentives. Many of these have shown promise, but have not been widely disseminated. The Patient Centered Medical Home involves team-based patient-centered primary care and disease management and is low risk. It may reduce return visits and achieve higher rates of disease management goals, and has been used most widely for five million patients in the Veterans' Administration [16]. Transitions of care programs reduce re-hospitalization among targeted populations by up to 50 % [8] and utilize care management teams to improve communication and patient education, as well as enhanced follow-up.

Hospital safety programs for specific conditions strive to reduce hospital acquired conditions among vulnerable populations. These programs are promoted by CMS's Partnership for Patients, part of the Tenth Scope of Work of the state Quality Improvement Organizations (QIO). State QIO's work under contract with CMS to assist physician offices, hospitals, nursing homes, home health agencies, and community partners to align care processes with national standards to ensure quality of care of beneficiaries. Among the hospital safety programs are ten priority areas (Table 1.1).

**Table 1.1** Hospital acquired conditions: ten priority areas of focus

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| 1. Adverse drug events |
| 2. Catheter-associated urinary tract infections |
| 3. Central line associated blood stream infections |
| 4. Injuries from falls and immobility |
| 5. Obstetrical adverse events |
| 6. Pressure ulcers |
| 7. Surgical site infections |
| 8. Venous thromboembolism |
| 9. Ventilator-associated pneumonia |
| 10. Reducing readmissions |

While integrated delivery systems of the 1990s failed to control costs, accountable care organizations (ACO's) including variable risk strategies, hold a promise of cost avoidance, maintenance of quality, and improved population health. ACO's are formed by voluntary healthcare organization providers and suppliers of services who accept blocks of unselected fee for service Medicare patients provided by CMS. These partners accept shared responsibility to coordinate care and deliver seemless, high quality care. Payment is dependent on the assumed risk structure and outcomes connected to coordination of care, disease management, and transitions of care. Reimbursement is thus linked to processes rather than production metrics. This is in stark contrast to fragmented care where providers receive different, disconnected payments. Early reports on the Pioneer ACO's, showed that 27 of the 35 exceeded fiscal targets [17].

There is early evidence that the wider community of physicians may be initially hesitant to lead and adopt new models of care which include more cost and value consciousness in medical decisions. These include bundled payments and team-based care strategies, decreased disparity in reimbursement among specialties, and changing incentives from fee for service models in favor of performance payment with shared risk [18]. This is indeed unfortunate as the healthcare system shifts from producer-driven to outcome (patient-centered) drivers with mandated reporting of individual quality measures. We urgently need physician input accepting key roles in making important decisions. There is tremendous opportunity for younger physicians especially to step-up and lead the way. Physicians understand what is best for the patient and are aware of clinical realities. They can work to ensure optimum patient care and physician acceptability, and enhance quality [19]. Physicians and their respective medical societies will need to guide consensus building efforts to develop patient centered quality and outcome measures targeting the things that matter, i.e. accurate and timely diagnoses, judicious testing, appropriate treatment interventions, and caring for the increasing numbers of patients with multiple co-morbidities and functional limitations. These measures must support patient valued physician characteristics including empathy, honesty, respect, and thoroughness. If they do not accept this challenge, physicians risk marginalization and all of society suffers.

Many professional societies have followed the lead of the American College of Physicians' Choosing Wisely Campaign, developing high value care recommendations. These are specialty-specific guidelines for cost-conscious care which eliminates unsafe and low value services that generate expenses with potential harm or no benefit. Only time will tell if new incentives and models of care and physician involvement, sustained over time, will be effective in improving the US healthcare system.

## Leadership Is a function of (Expertise, Change, Risk, Persistence, and Trust)

A wise man once said: "If people follow you, you're a leader." Physicians have great potential when they become involved as agents of change. Viewed as experts in healthcare matters, the public has a high regard for physicians and in fact looks to them for direction and leadership in matters involving health. In my experience, the public, government, and business as a rule, still defers to physicians as the healthcare experts. This acknowledgement is not only regarding personal health, but also in policy arenas. Physician organizations are especially urged to provide input, helping to shape critical healthcare decisions.

Leadership can take many forms, but it is always personalized. And it is always about change. There is always one person, a leader, who begins anything. A leader possesses competency and engenders trust to create a shared context, inspiring others to work together to achieve common goals. This creates a structured support to guide transformation. Leadership involves risk tolerance, yes and persistence. A leader is motivated and passionate and ignites this in others. Some leaders lead by example and followers respond by imitation. Others facilitate shared leadership functions and provide advice to influence and enable changes at all levels.

Although many seek leadership positions in order to influence change, in truth leadership occurs at many levels and different types of leadership require different skill sets. Some leaders create a membership-participatory organization style rather than a top-down environment. These leaders contribute experience to influence decision making and are foundational for building a culture of quality and safety [20]. Their influence is critical in creating measurable objectives and work plans leading to system-wide changes. They may initiate activities voluntarily and function in acting roles, creating new positions for others. Informal leadership roles do not always provide official recognition, so these agents of change often possess a selfless dedication. But all are leaders.

Leaders have a clear vision with a discipline and commitment to work for change. They frame the issues and give a sense of scale, engaging others in causes bigger than themselves. Authentic leaders are competent and personally trustworthy. They are good communicators, building relationships through empathy, understanding, and inspiration. An inclusive leadership style acknowledges other's values and points of view, and energizes them to create committed action. While the mind weighs facts, the heart seeks meaning, and the effective leader manages both to give meaning and relevance to the cause for change.

Many true leaders are conferred leaders, acknowledged either formally or informally for their competence and experience and consulted for their expertise to guide the discussion, formally and informally. They stimulate and support the planning, implementation, and evaluation of change processes. These agents of change form a foundation for building a culture of quality and safety, complementing existing

organizational structures. A responsible organization ignores sound advice at its own peril. Many physicians adopt executive and administrative responsibilities, but may not be recognized as executives. Not all leaders are in charge of institutional levers, nor appointed by others in authority. Indeed, appointment to positions of authority can potentially alter a leaders' commitment to change, placing them in conflict with new and different priorities. Witness the fate of many politicians elected to office with promises of change only to be confronted with the realities of competing demands of the office. Regrettably, some individuals appointed to positions of authority are not, in fact, effective leaders.

Becoming involved as physician leaders includes volunteering to quality improvement and safety committees. It involves accepting appointments to hospital, organization, and practice boards. Familiarity with organizational performance metrics and outcomes measures are also critical prerequisites to articulating strategies to move organizations.

## Barriers to Change

Many good ideas are not always followed. But the specter of Medicare insolvency and the continued rise of US healthcare spending is forcing us to focus on increased costs. There are many good proposals: shared resources, improved communication, incentivizing shared outcomes. Visibility is a potential problem to an evolving leader. Marketing, consultation, and being helpful to organizations are effective strategies for the spokesperson advocating change. It's all about achieving common overlapping goals, a win-win-win, and being helpful as well as adaptable. It's not about who gets credit. In the final analysis, it's the outcome – not who's the genius behind the idea.

Resistance to change is expected from those enjoying the benefits of current fee for service, procedural, and volume-based system. Rallying under the banner of choice, freedom to select providers becomes a false promise for disenfranchised populations when access is denied, care delayed, and preventive services non-existent. It also takes leadership to address the health needs of vulnerable populations, as these do not traditionally participate in the decision making process for benefits, and are not prone to self-management.

Incentives must be changed to enhance collaboration. It would be unfortunate if the healthcare system has to fail, the public has to suffer more, spend more before healthcare changes. There are many new models of care to provide guidance and incentivize change.

The next decade will require an all-hands-on-deck approach to participate in meaningful, effective, patient-centered, and physician- directed change.

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