Geriatrics: The Baby Boomers Are Here

Kaiser Permanente Southern California
Nancy E. Gibbs, MD
April 6, 2011

Unique Challenges to Geriatric Care

- Increasing aging membership
- Increasing complexity of nursing home care
- Increasing prevalence of chronic conditions and risk factors
- Increasing numbers with multiple chronic conditions and risk factors
- Declining functional status
- Growing body of evidence-based interventions in Geriatric care
- Insufficient number of geriatric specialized providers
- Opportunities and challenges associated with Medicare financing

The future is a tidal wave unless we act now!
Well the future is here!!!
The Opportunity

Opportunities exist to improve geriatric care: reducing morbidity and mortality and increasing satisfaction

- Dementia screening and follow-up
- Dense bones (osteoporosis screening & treatment)
- Depression screening and treatment
- Decision-making (advanced care planning)
- Drug safety
- Delirium prevention
- Decubitus prevention and care
- Death and Dying

Fitting Geriatric Care into Our System of Care

Outpatient
- Dementia
- Dense Bones
- Depression
- Decision-Making
- Drug Safety
- Care Management

Hospital
- Delirium
- Deconditioning
- Decubitus Prevention

Continuing Care
- Home Health
- SNF/LTC
- Palliative Hospice

Have we gotten there yet? And … is it enough?
## The Continuum of Senior Care

### ROBUST
- Preventive care
- Immunizations
- Health Risk Assessment for Common Geriatric Conditions
- Exercise
- Advanced Care Planning

### AT-RISK
- Common Geriatric Conditions Treatment
- Drug Safety
- Dense Bones
- Decision making
- Dementia
- Depression
- Geriatricize Chronic Care Programs

### FRAIL
- Geriatric Care Management
- Palliative Care
- Hospice

---

### Geriatrics 2011

The projections of yesterday are here today!
The Age Wave!!
1st Boomers Turned 65y/o January 1, 2011

KP’s Age Wave!!

Senior Membership

<table>
<thead>
<tr>
<th>Age</th>
<th>2002</th>
<th>2013 (Est.)</th>
<th>change from 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>199,000</td>
<td>313,000</td>
<td>57%</td>
</tr>
<tr>
<td>75-84</td>
<td>102,000</td>
<td>129,000</td>
<td>27%</td>
</tr>
<tr>
<td>&gt;85</td>
<td>25,000</td>
<td>41,000</td>
<td>64%</td>
</tr>
</tbody>
</table>

Age 2011
| 65-74 | 248,160 | 25% |
| 75-84 | 125,643 | 23% |
| >85 | 41,468 | 65% |

Age 2010 2011 change
| >100 | 257 | 334 | 30% |
Expanding Model Programs & Adding New Ones

**Growth potential**
- Expansion of EOL programs
  - Home-based PC
  - Internalize all Hospice
  - Ambulatory PC
- Care models
  - Special Needs Plan Care Management Model
  - Assisted Living Facility Rounding services
  - Geriatric Primary Care
- Clinical Geriatric Safety Initiatives
  - High Risk drug reduction
  - Pressure Ulcer prevention
- New To KP Medicare Member program
- Health Connect optimization

**On the Horizon**
- **Medicare 5 Stars**
- Clinical Geriatric Safety Initiatives
  - Delirium prevention
  - Medication Safety Nets
- Advanced Care Planning as the quality standard of care
  - Provider education
  - Skilled resources
  - Competencies and accountability
- Geriatric Proactive Care
  - Screening and Intervention
    - Fall risk
    - Urinary Incontinence
    - Dementia
  - Dementia education and coding

---

**Medicare Star Quality Demonstration**

*Project Update*
*January, 2011*
What is Medicare 5 Star?

- Medicare 5 Star is a CMS rating system based on quality and member experience with the plan.
  - KP Southern California and Northern California are considered one Medicare Advantage (MA) plan to CMS.

- The Affordable Care Act introduces quality bonus payments for MA programs: a strategy for implementing quality improvement in health care.

- The 2012 quality bonus payment is for 4 or more stars in the 5 star quality rating system.

KP goal = 5 Stars !!!

Medicare Star Quality Ratings

*Note: CMS can add or subtract measures in future reports. At CMS' discretion, other existing performance measures may be included as "Star Rating" measures tied to bonus payments.
Primary Clinical 5☆ Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011 SCAL Project</th>
<th>2012 SCAL Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Cholesterol Screening – cardiovascular care &amp; diabetes care</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Glaucoma Testing</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Appropriate Monitoring of Patients Taking Long-term Medications</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Access to Primary Care Doctor Visits</td>
<td>5</td>
<td>Not available</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes Care – eye exam, kidney disease monitoring, blood sugar control, cholesterol control</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Testing to Confirm Chronic Obstructive Pulmonary Disease</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Mission for KPSC
Geriatric Care

“Kaiser Permanente Southern California delivers coordinated, seamless, cost effective geriatric care programs that promote ‘successful aging’ and meet our seniors’ needs whether they are health promoting, restorative or palliative.”

Successful Aging Model: adapted from Rowe and Kahn, *Successful Aging, 1996.*
KP VISION THEMES

Position us well

- Our members, physicians & staff are highly satisfied
- Services are patient centered, well coordinated, and integrated across the continuum of care
- KP Senior friendly providers, systems, processes
- KP is a strong advocate for quality Senior Care
- KP recognized as a leader in Senior Care
- KP is accountable for ensuring “Excellent Care”

2011 Initiatives

- Hospital
  - Malnutrition identification and intervention
  - Geriatric Safety Order Set
    - Delirium and Deconditioning prevention
- STAR – Safe Transitions, Avoiding Readmissions
  - Improved communication with handoffs
  - Timely follow-up visits
  - Medication reconciliation
2011 Initiatives

- Dementia
  - Early identification and coding
  - Appropriate treatment and management
- Falls
  - Screening for risk
  - Evaluation and interventions
- Urinary Incontinence
  - Screening and intervention

Continuing Initiatives

- Healthy Bones
  - Screening and treatment
  - Post-fracture intervention
- Drug Safety
  - Drugs to Avoid in the Elderly Initiative
    - DUAT and Geriatric High risk drug task force
  - Drug disease Interaction
    - Dementia and TCAs and anticholinergic medications
    - Falls and TCAs, antipsychotics and sleep agents
    - Chronic kidney disease and NSAIDS
Continuing Initiatives

- Pressure Ulcer Prevention
- Depression care management, screening and treatment for high risk population
- Optimizing HealthConnect to support patient safety and geriatric initiatives
  - Best Practice Alerts
  - Order sets
  - Geriatric questionnaires and flow sheets
  - High risk population identification

Continuing Initiatives

- Medicare Onboarding Pilot
  - New to KP Senior Advantage members
  - Welcome packet, 40 minute visit
    - Health assessment
    - Medication reconciliation
    - Coding
    - Frailty screening
- Woodland Hills GeriPal pilot
  - Geriatric primary care combined with home visits
- Assisted Living Rounding service
Expanding Initiatives

- Life Care Planning
  - It’s about the conversation
    - Advance Directives
    - POLST
  - Medical Center Champions
- EOL Online educational modules
  - Talking with patients about CPR,
  - When and how to approach completing a POLST
  - Breaking Bad News: a strategy for successful communication
  - The Family and Serious illness from Conflict to Consensus
- Health Connect Care Activity Tab

Care Directives Activity
Care Directives Activity - Summary

• Summary view shown available from within the Care Directives activity
• Data output from Care Directives activity allow for custom print groups for use in summary report
• Layout in summary report determined by region

End of Life Care

• Palliative Care
  • Inpatient Palliative Care Consultation
  • Multiple Ambulatory pilots emerging
  • Expanding HBPC and Hospice
    • Criteria revision
  • Improving EOL care with attention to pt/family centered places to die if cannot be at home
Palliative Care ≠ “Comfort Care Only”: Examples of Other Goals

- Physical Comfort
- Coordinated Care
- Preserving Function
- Accessing Health Care Services
- Maintaining Nutrition
- Concurrent Treatment
- Spiritual Support
- Practical Support
- Understanding Options
- Sense of Control
- Emotional Support
- Lessen Family Burden
- Preserving Function

Special Programs

- Special Needs Plan:
  - 30,000 Medicare/MediCal members
  - Many CMS requirements
    - Annual assessment and care plan
    - Follow through transitions of care
    - Medical Center Interdisciplinary Care management teams
    - Goal: Improve health outcomes and decrease utilization
  - Building the chassis for other high risk populations
Case Study: Mrs. Smith

- 70 year old w/ hypertension, glaucoma, history of wrist fracture secondary to a fall, gout, mild arthritis, anxiety, vertigo and basal cell carcinoma. She takes 8 prescription medications.
- Her risks:
  - dementia 10%
  - major depression 15%
  - hip fracture > 17%
  - Cardiovascular event > 10%
  - hospitalization 99 x
  - an adverse drug event 10%

Interventions for Mrs. Smith

- Late-life depression screening and Rx
- Dementia screening
  - Cognitive preservation strategies encouraged
- Advanced care planning
  - Advance directives completion encouraged
  - Goals of treatment and care preferences discussed
  - Glaucoma follow-up and Rx
- Exercise prescription given
- Medication review
  - Elimination of drugs that cause falls, confusion or depression
- Osteoporosis screening
  - Treatment initiated including:
    - medication
    - fall risk
    - fall prevention strategies
- Hypertension follow up and medication adjustment
Outcomes

**Member:**
- 40% less chance of hip fracture
- Reduced chance of cardiovascular event
  - 40% decreased risk of CVA
  - Decreased risk of dementia development
- 45% chance of improved depression
- Decreased chance of adverse drug event
- Will not die in ICU, per her advance directive

**KP:**
- 40% less hip fractures
- 3,600 less Acute days
- 13,000 less SNF days
- Decreased stroke, CHF and vascular dementia
- Improved depression in 45% of older members
  - Improved function and quality of life in 12,000 members
- Decreased ADE related costs
- Reduced use of inappropriate, costly ICU

Mrs. Smith:
Results of Geriatric Interventions

- 83 y/o, with HTN, gout, moderate arthritis, osteoporosis, glaucoma, recurrent basal cell carcinoma, mild hearing loss, minimal short term memory loss.
- Still on 8 different Rx plus calcium
- Reads a book a week
- Plays bridge or any other card game you challenge her
- Exercises regularly
- Plays golf twice a week
- Has an advance directive
- Hospitalized once in the past 13 years
Mrs. Smith: 2011

- 91 y/o, w/ hypertension, glaucoma, osteoporosis, compression fracture due to a fall, gout, moderate arthritis, occasional vertigo, skin cancers; has had cataract operation (20/20 vision) and now wearing hearing aids.
- Only takes 5 prescription medications.
- Hospitalized for dehydration and sepsis from urinary tract infection, several days of weakness prior to hospitalization.

Mrs. Smith:
What shouldn’t happen

- Worst case scenario
  - Kept in bed
  - Foley catheter placed
  - Gets confused
  - Given sleeper
  - Becomes deconditioned
  - Develops pressure ulcer
- Transferred to the nursing home
  - Stops eating
  - Aspirates
  - Becomes septic
  - Develops C-diff after antibiotic treatment
  - Level of cognition never improves
- Family opts for comfort care and elects hospice

It should not have happened this way…
Mrs. Smith: a better possibility

- Alternative - Geriatric safety bundle in place
  - Oriented by the nursing staff during hourly rounding
  - Ambulated to the bathroom and then in the hall
  - Is up in chair for meals
  - No sleeping medication given despite request
- Able to go home at her request on oral antibiotics on the 3rd day
  - Gradually increases activities
    - Within 2 weeks is back playing bridge
    - 3 months playing golf
    - Socializing with family and friends

Mrs. Smith: More typical scenario and our opportunity

- Has developed mild cognitive impairment
  - 50% chance of developing dementia
  - Higher risk of delirium when hospitalized
- Evidence of mild heart failure
- Renal insufficiency whenever ill
- Still functional but “frailing”
  - Increase risk of falls and fractures
  - Increased risk for depression
  - Increased risk of polypharmacy
- Has “slowed down”
**“Successful Aging”**

**Proactive Interventions**

- Withdraw from all high risk medication
- Monitor and encourage adequate nutrition
- Balance getting “good numbers” with anticipated life expectancy
  - Cholesterol
  - HgbA1C
- Assure care preferences delineated and proxy named
- Check vision and hearing
- Encourage physical activity and socialization
- Assure a safe environment, and plan for increased care if dementia and debility progress

---

**The seven promises of a reliable care system:** Joanne Lynn, MD

- You will receive the correct medical treatment
- You will never have to suffer from any distressing symptoms that you do not want to have
- Your care will be seamless
- There will be no surprises
- Your care will be customized to you
- Your family will be involved in your care per your wishes
- We will maximize your health and function regardless of where you are in life
KP’s Umbrella of Care – It’s where we need to be!