Next Steps in Making America's Healthcare Age-Friendly

David B. Reuben, MD

Archstone Foundation Chair and Professor

David Geffen School of Medicine at UCLA

Learning Objectives

1. Describe key challenges to delivering care for older adults in 2024/2025.
2. Describe strategies to prepare America's workforce to deliver age-friendly care.
3. Describe new and innovative healthcare delivery models that can disseminate age-friendly principles across our healthcare system

The Problem

Clinicians are unable to provide high quality of care for conditions affecting older persons within the context of busy primary care practices.

Health care quality for vulnerable elderly

- Assessing Care of the Vulnerable Elderly (ACOVE)
  - identified elders at increased risk for death or functional decline
  - created quality indicators based on literature review and expert panel for 22 conditions
- Overall, 55% of Quality Indicators passed
- Worse for geriatric than for general medical conditions (31% versus 52%)
- Care for specific conditions varies greatly
  - Stroke 82%; end-of-life care 9%

Wenger NS et al. Ann Int Med 2003

Barriers to good health care

- Insufficient cognitive capacity
- Not enough time
- The health care system isn’t a system
- Rewards are wrong
- Competing agendas

Competing agendas

Patient	Physician	Payer
Alleviation of symptoms	Addressing patient concerns	Cost of care
Live a long life	Managing the patient's care	Technical quality of care
Social issues	Managing diseases	Patient Satisfaction
Advice/Social interaction	Administrative (documentation)	

Other Threats to Well Being

- Overhead (common denominator is “time”)
  - Following up on tests
  - Coordinating care
  - Responding to in-basket
    - Calls
    - E-mails/text messages
    - MyChart messages
- Transactional rather than personalized care

Transactional and Personalized Aspects of Patient Care

Transactional	Personalized
Data gathering and entry	Synthesizing data from diverse sources
Preventive care	Customizing care for individual patients
Guideline-based disease management	Adjudicating competing needs of multiple conditions
Disease-specific patient education	Negotiating individual treatment plans and agreeing upon expected outcomes
Documentation	Performing procedures
	Advocating for individual patients

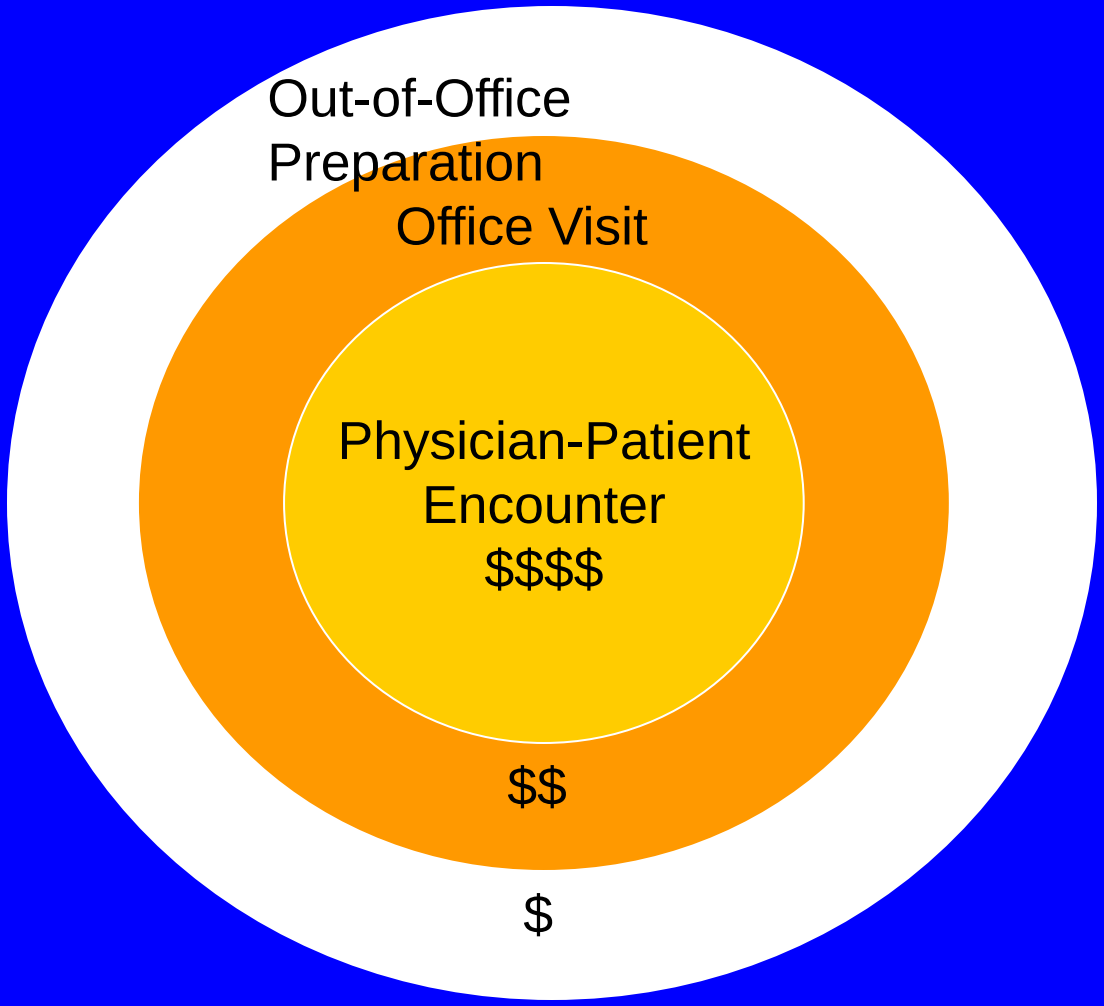
Reuben DB, Sinsky CA. From Transactional Tasks to Personalized Care: A New Vision of Physicians' Roles. Ann Fam Med. 2018 Mar;16(2):168-169. doi: 10.1370/afm.2203. PMID: 29531111; PMCID: PMC5847358.

Practice Redesign

- Combines interventions aimed at structure and process
- Aims to improve quality and/or increase efficiency by:
  - Fixing a problem or inefficiency in patient care
  - Exploiting technology
  - Using different people or people differently

Fixing an inefficiency

1) Delegate data collection



1. Reduce time but increase effectiveness/efficiency of the inner circle
2. Always push to outermost possible circle whenever possible

Delegation to Patients

- Pre-visit questionnaire
  - Initial
  - Follow-up
- Lists
- Diaries

Delegation to Office Staff

- Screening/Case identification
- History gathering
  - Following up on triggers
- Medications/allergies
- Enhanced vital signs/physical exam
  - Orthostatic blood pressure readings
  - Visual acuity testing
  - Monofilament
  - FRAX (Fracture Risk Estimator)
  - PHQ-9/GAD-7
- Patient education

Effect of Delegation on Quality

- 8 ACOVE studies, 4776 persons ≥ 65
- Quality indicators for falls, urinary incontinence, and dementia
- If delegated to NP, PA, or RN, 1.4 X more likely to be passed than if physicians' role

Lichtenstein B JAGS 63:2164–2170, 2015

Other Ways to Fix Inefficiencies

2) Minimize data recording time

- Dictation/voice recognition
- Templates
- Dot phrases
- Computerized medical records increase documentation time
  - http://www.cdc.gov/nchs/data/databriefs/db129.htm 2013
  - https://pubmed.ncbi.nlm.nih.gov/27595430/ 2016

3) Keep information needed for decision-making readily available

4) Delegate plan execution

Exploiting Technology

- EHR: (a couple of TNTC examples)
  - copy forward
  - reflex additional testing
  - add on testing
  - reminders
  - active (e.g., ADT notification) engagement
  - patient entry into medical records
- Telehealth (mobile and remote technology)

Using Different People

- Scribes
- Comprehensive Care Coordinators
- Community Health Workers/Promotores
- Care Navigators
- Dementia Care Assistants

Structuring Visits and Workflow: Using Doctors and Staff Differently

- ACOVE -2 Practice Redesign
  - Case finding
  - Delegation of data collection
  - Structured visit notes to guide appropriate care processes
  - Physician and patient education
  - Linkage to community resources

-Reuben et al. J Am Geriatr Soc. 2003;51:1787-93.

Effects on quality of care by condition in ACOVE-2 intervention

	Usual Care	ACOVE-2
Overall	22-32%	37-71%
Falls	23-40%	44-79%
Incontinence	17-37%	37-64%
Dementia	38-44%	43-60%
Depression	28-61%	51-63%

In each, significant differences between UC and ACOVE for overall, falls and UI; variable significance for depression and dementia

Using people differently: Co-management

- Two or more health care providers jointly managing the patient's medical care to achieve the best quality and outcomes
- Many models, most focus on specific conditions (e.g., cancer, dementia) or on multiple conditions and coordination of care

Key steps in creating a co-management program

- Identify the problem and target population
- Find a product champion
  - Unafraid to fight battles
  - Committed to seeing it through
- Select the model and people
- Specify the process of care
- Get input from stakeholders
- Establish metrics for success
- Expect false starts
- Get the word out about the program

Co-management: Quality of Care

Geriatrics Conditions: NP co-management

Condition	Study	Physician alone	Co-management with nurse practitioner	P-value
Falls	Ganz, 2010	17%	44%	.002
Falls	Reuben, 2013	32%	78%	<.001
Incontinence	Ganz, 2010	26%	58%	.01
Incontinence	Reuben, 2013	20%	66%	<.001
Dementia	Reuben 2013	38%	59%	<.001
Dementia	Jennings, 2016	38%	92%	

The UCLA Alzheimer's and Dementia Care Program

Mission: To partner with families, physicians, and community organizations to:

- maximize person living with dementia function, independence, and dignity,
- while minimizing caregiver strain and burnout.

- Began in 2011 with philanthropic funds
- As of Sept 19, 2024, 4296 patients have been enrolled; 1043 are currently active, 29 are scheduled to be seen and 328 are waiting to be scheduled; 10-25 new referrals/week

UCLA Health ADC Alzheimer's and Dementia Care PROGRAM DEMENTIA Care Aware

The Program

Approaches the patient and caregiver as a dyad; both need support

Provides comprehensive care based in the health system that reaches into the community

Recognizes that this care is a long journey.

Uses a co-management model with Nurse Practitioner Dementia Care Specialist (DCS) who does not assume primary care of patient

UCLA Health

ADC Alzheimer's and Dementia Care PROGRAM

DEMENTIA Care Aware

1 Year Outcomes for patients and Caregivers

	Patient	Caregiver
Cognition (MMSE)	Worse	
Functional status (FAQ)	Worse	
Behavioral symptoms (NPIQ)	Improved	
Distress because of behavioral symptoms (NPIQ)		Improved
Caregiver strain		Improved
Caregiver depression (PHQ9)		Improved

UCLA Health ADC Alzheimer's and Dementia Care PROGRAM DEMENTIA Care Aware

Utilization and Costs

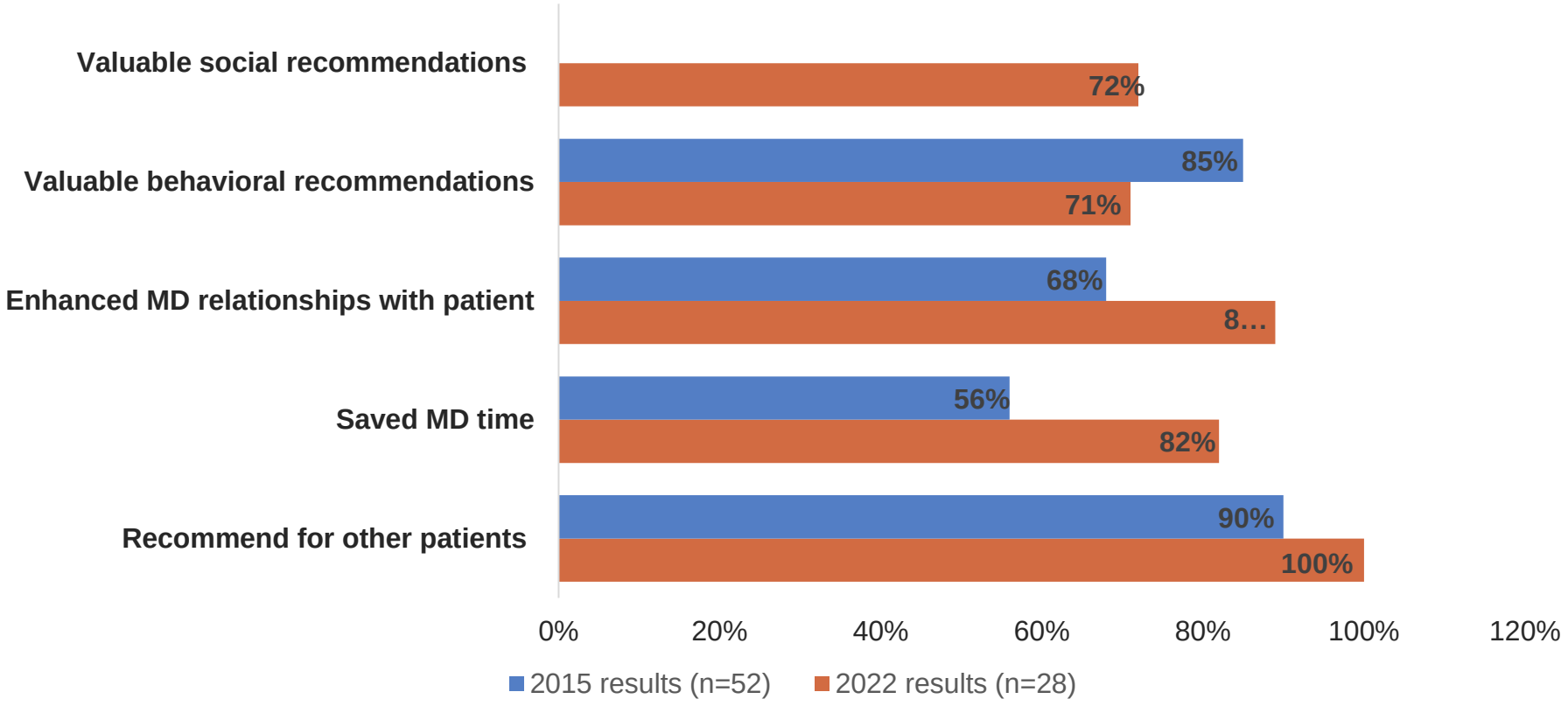
Type of Care	Impact
Hospitalizations	▼ 12%
ED visits	▼ 20%*
ICU stays	▼ 21%
Hospital days	▼ 26%*
Nursing home placement	▼ 40%*
Hospice in last 6 months	▲ 60%*

Total Medicare costs of care:
▼ $2,404/year *

* p<.05
Based on NORC external evaluation of CMMI Award using fee-for-service claims data and UCLA ACO data September 2015- September 2017

UCLA Health
ADC Alzheimer's and Dementia Care PROGRAM
DEMENTIA Care Aware

Physician Satisfaction



Guiding an Improved Dementia Experience (GUIDE) Model

- On July 31, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary nationwide model – the Guiding an Improved Dementia Experience (GUIDE) Model that aims to:
  - improve the quality of life for people living with dementia
  - reduce burden and strain on unpaid caregivers of people living with dementia, and
  - prevent or delay long-term nursing home care

GUIDE Model: Design

1. **Defining a standardized approach to dementia care delivery** – 9 components
2. **Providing an alternative payment methodology** – CMS will provide a monthly per-beneficiary payment
3. **Addressing unpaid caregiver needs** –by caregiver training and support services, including 24/7 access to a support line, as well as connections to community-based providers
4. **Respite services** – Payment for temporary respite services provided to a beneficiary in their home, at an adult day center, or at a facility that can provide 24-hour care
5. **Screening for Health-Related Social Needs** – and help navigate them to CBOs to address

Thinking About the Future

Increasing clinicians' knowledge, skills, and attitudes (e.g., traditional CME, ECHO)

versus chronic disease self-management

- Lorig KR, *et al* Med Care. 1999 Jan;37(1):5-14. doi: 10.1097/00005650-199901000-00003. PMID: 10413387.

versus population health

- The health outcomes of a group of individuals, including the distribution of such outcomes within the group.
  - Kindig D , Stoddart, G. Am J Public Health.2003;93:380–383
- All persons' needs are met comprehensively
- And least expensively

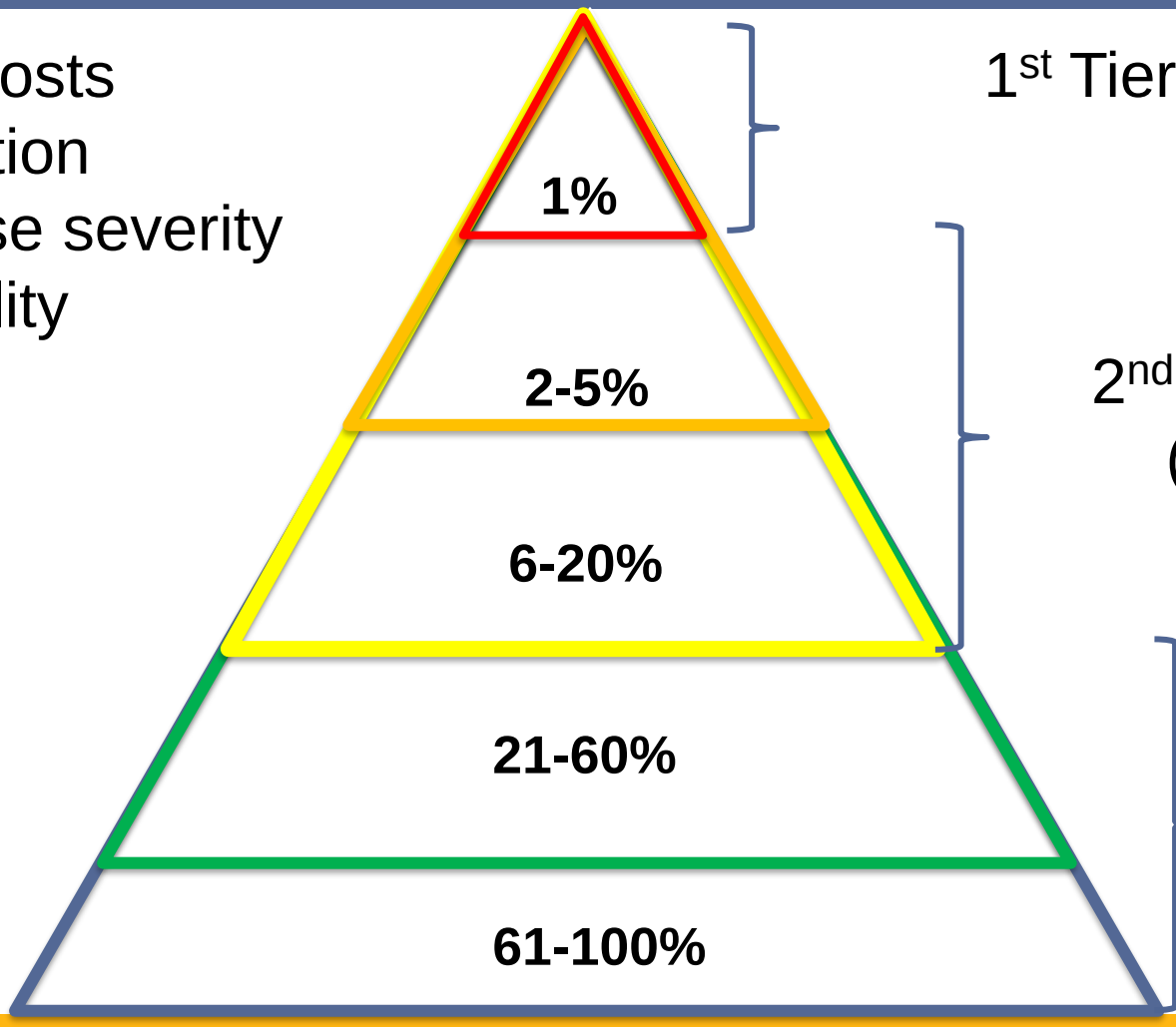
- Not mutually exclusive

A Model for Population-based Care

Metrics

- Total costs
- Utilization
- Disease severity
- Disability

Interventions



1st Tier (1%)

2nd & 3rd Tier (2-20%)

4th & 5 th (21-100%)

Population-based Interventions

- Ensure quality (Donabedian)
  - Structure
  - Process
  - Outcomes

- N Engl J Med. 2016 Jul 21;375(3):205-7

The Bottom Line

- Practice redesign efforts can improve the quality of care
- Population health approaches will be needed to ensure that all patients receive the right type and amount of care
- Co-management programs are promising for chronic conditions that need a lot of attention and for appropriate patients
- It takes a TEAM!

Closing Slide

- David B. Reuben, MD
- Archstone Foundation Chair and Professor
- David Geffen School of Medicine at UCLA
- dreuben@mednet.ucla.edu