
# Managing Chronic Care Populations

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THE ELEVENTH ANNUAL INTERCOMPANY LONG TERM CARE INSURANCE CONFERENCE
ILTCI

# Chronic Disease: Epidemic of Unparalleled Proportions

## The Nation

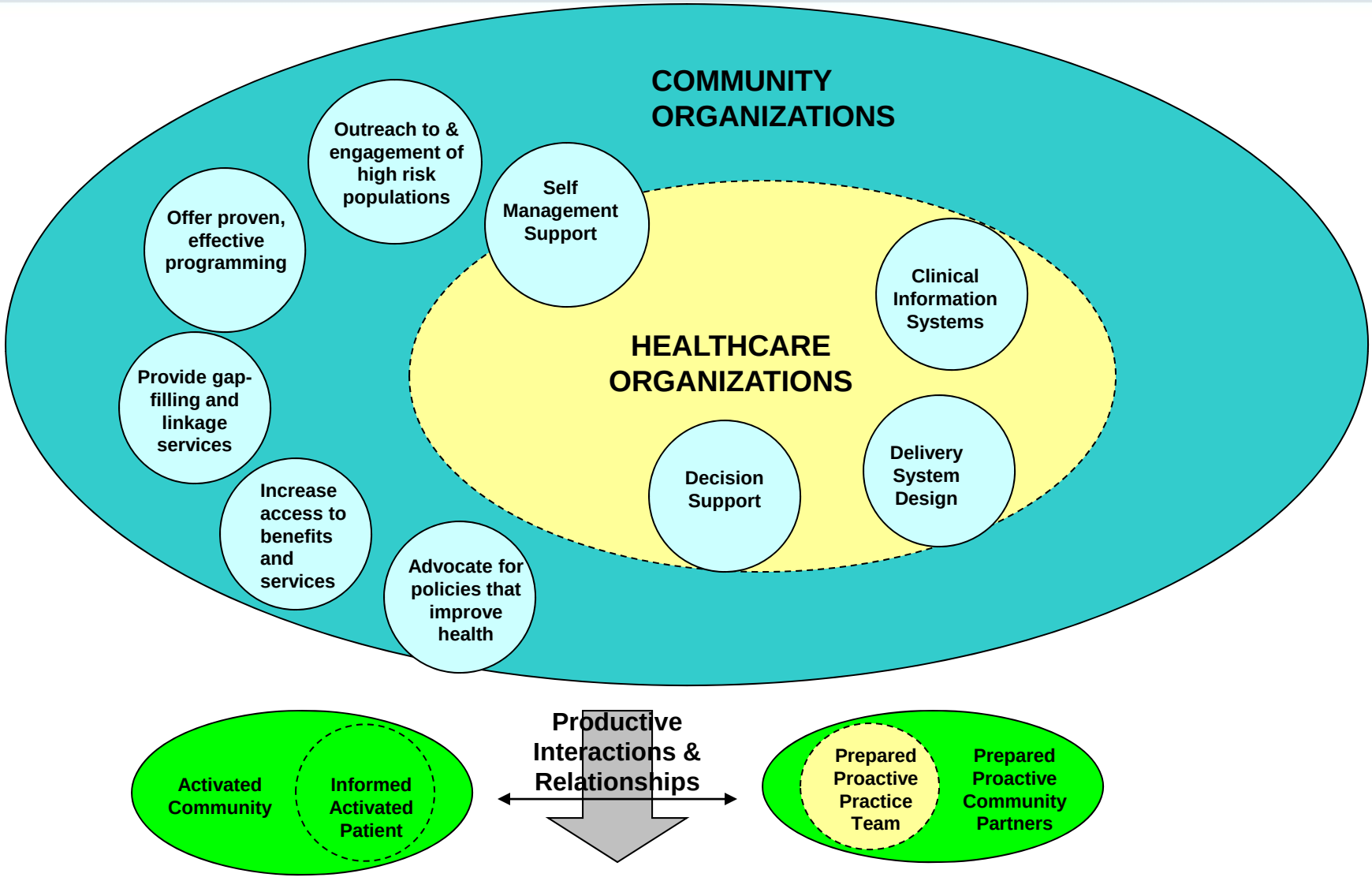
- Forty-two percent of the American population – 128 million people – live with at least one chronic medical condition; these numbers are expected to rise by 25% over the next 20 years.
- The medical care costs associated with people with chronic disease account for more than 75% of the nation's $1.4 trillion medical care costs.
- Two-thirds of the increase in National healthcare spending is associated with the treatment of chronic conditions.
- For older adults, falls are the #1 cause of fractures, hospital admissions for trauma, loss of independence and injury deaths.

# Chronic Disease: Epidemic of Unparalleled Proportions

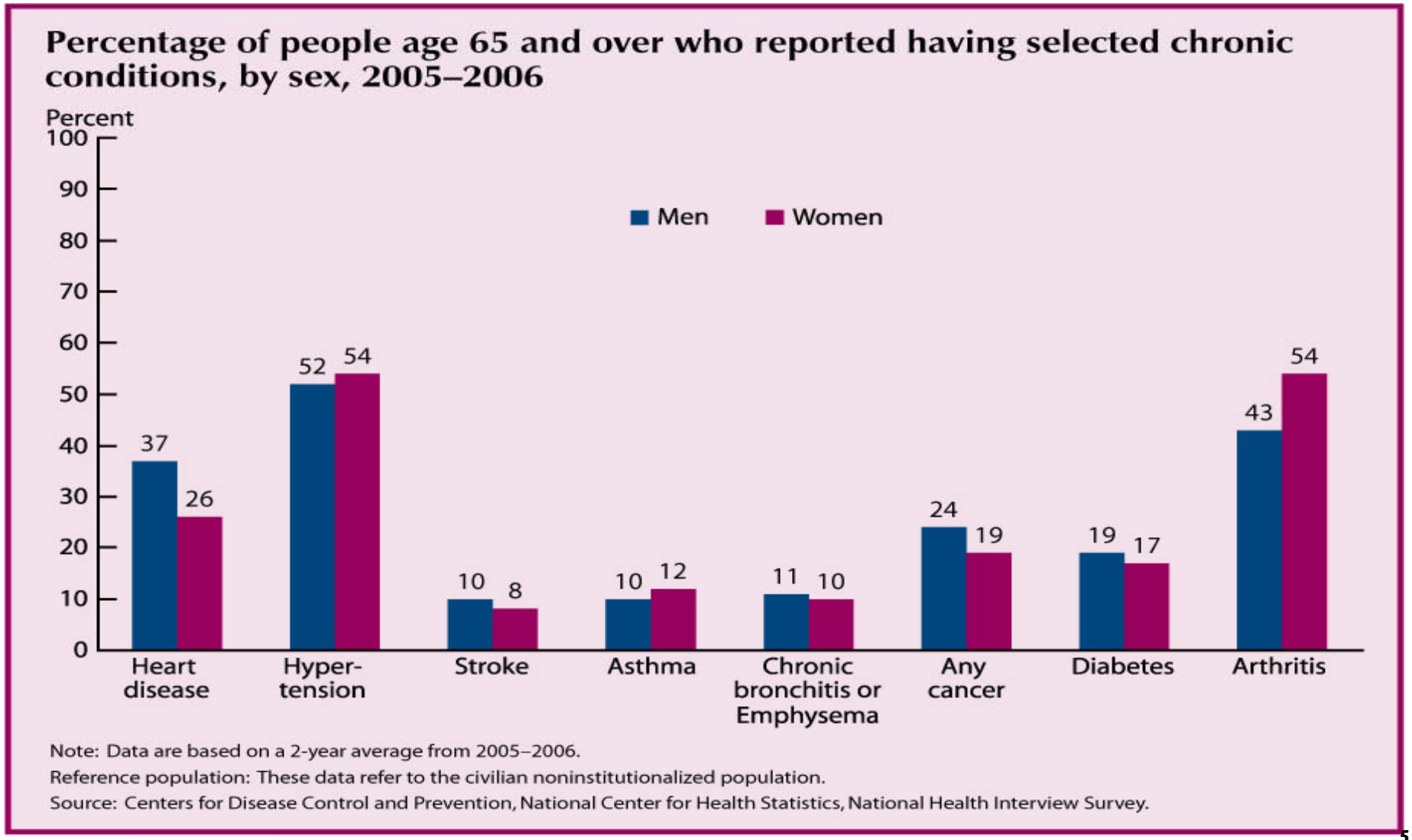
**Older Adults and the programs that serve them**

- 95% of Medicare spending for older adults is attributed to chronic conditions due to:
  - Fragmented, inadequate care;
  - Inability to identify problems for early intervention;
  - Poor communication between providers of care, patients, and family caregivers;
  - Weak adherence by patients.
- **Medicare beneficiaries with 2+ chronic diseases comprise 63% of the total population yet they account for 95% of Medicare spending** and this includes 12% of beneficiaries with 5+ chronic conditions accounting for 45%.
- In 2007, LTC insurance policies paid $4 billion in claims on behalf of policy holders, a small fraction of $200 billion in national LTC spending.

# Need to Strengthen the Community Portion of the Chronic Care Model



# Chronic Health Conditions



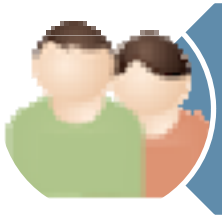
# Interventions for Chronic Care Management

- There is a growing body of "evidence" that three types of interventions for Medicare beneficiaries with multiple chronic conditions have been shown to be especially effective in maintaining or improving health outcomes, reducing costs and preventing avoidable hospitalizations:
  - **Self-care interventions** (Lorig and Wheeler) also known as empowerment models and other evidence-based disease prevention and health promotion programs (AHRQ, CDC, AoA studies);
  - **Care transitions** interventions (Naylor and Coleman); and
  - **Coordinated care** interventions (select sites from the Medicare Coordinated Care Demonstration and experience in Medicaid HCBS)

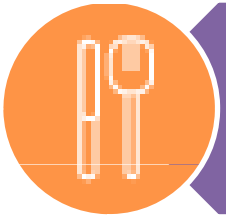
# Core Competencies

Care Management

Care Transitions



Integrated Long Term Care



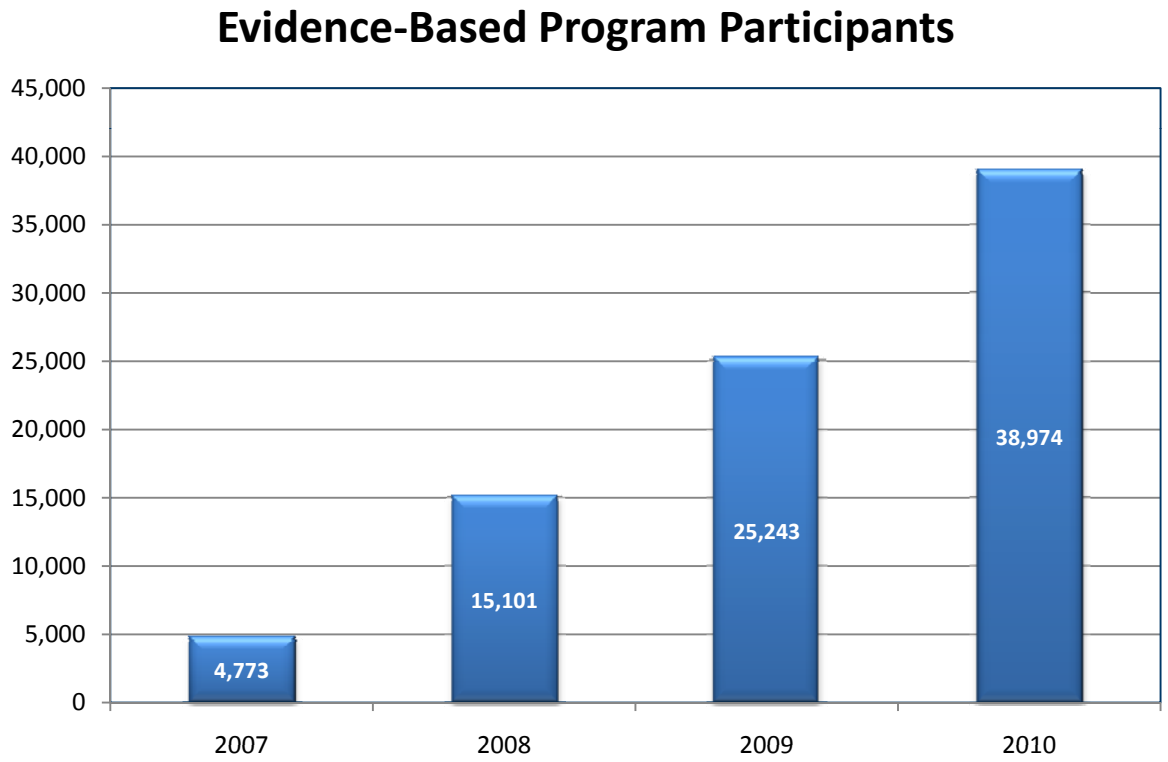
Meals & Nutrition Management

# Self-Care and Empowerment Programs

- There is growing evidence that self care and other empowerment-based programs provided in community settings and over the internet can improve health and reduce cost.
- Perhaps the best known and best researched self-care program is Stanford's Chronic Disease Self Management Program (CDSMP).
- Other community-based programs with strong evidence base and growing national presence include:
  - A Matter of Balance (addresses fear of falling and balance).
  - EnhancedFitness (physical fitness for older adults).
  - Healthy IDEAS and PEARLS (depression programs for case management clients).
- ***Communities Putting Prevention to Work Chronic Disease Self-Management Program***, funded by the American Recovery and Reinvestment Act of 2009, funded 45 states, Puerto Rico and the District of Columbia to provide self-management programs to older adults with chronic diseases build statewide delivery systems and develop the workforce that delivers these programs.
- There is a critical mass of evidence-based self care/prevention programming, including CDSMP, now being provided by community organizations. There is widespread demand by these agencies for support in expanding current efforts.

# Program Reach–All Evidence-Based Programs

- 14 programs reaching 84,091 older adults in 46 states, District of Columbia, and Puerto Rico



# History of Program Adoption

| Years of Growth | |
|---|---|
| 2001 | 4 communities |
| 2003 | 14 communities |
| 2006 | 16 states |
| 2007 | 27 states |
| 2010 | 46 states, DC, & Puerto Rico |

- Programs offered via 737 host organizations and 4,070 implementation sites

# Community Partnerships Key to Success

- ***ILS' Foundation*:** Evidence-based disease prevention & health prevention programming in both English and Spanish and limited Creole in low-income, minority target area:
  - Chronic Disease Self-Management
  - Diabetes Self-Management
  - Matter of Balance,
  - Fit & Strong
  - Workshops provided in diverse community settings including: health plan clinics; senior centers; HUD housing; and local libraries.

- ***Healthy Aging Regional Collaborative:*** funded by Health Foundation of South Florida to create a partnership of providers across three counties to create a substantial diffusion of programs that will result in a positive public health impact.
  - Programs mentioned above plus EnhancedFitness and Healthy IDEAS.
  - Two-years since start-up of operations and over 13,000 program completers
  - ILS' board member
  - 2011 Recipient of NCOA's Arthur Fleming Award

# Care Transitions

- Center for Medicare and Medicaid Services: **National Readmission Project** – subcontractor for Florida demonstration site.

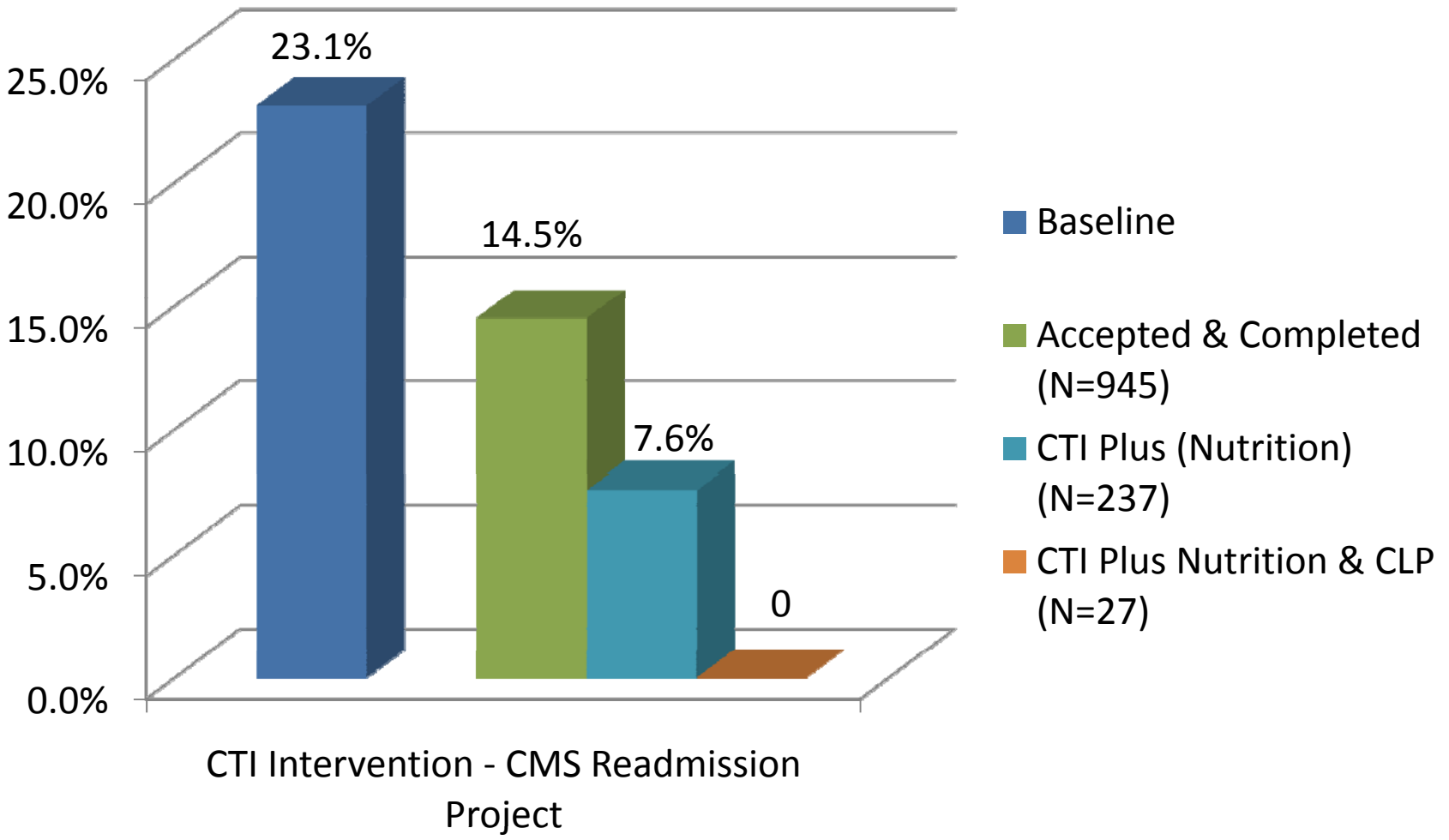
- Developed and implemented proprietary **Post-Acute Support System (PASS®)**
  - Based on Care Transition Intervention (CTI$^{SM}$) Program developed by Dr. Eric Coleman, University of Colorado.
  - Added components:
    - Nutrition Care Management (as a 5$^{th}$ pillar)
    - Nursing Home Diversion
    - Medical Home Coordination
    - Participant Directed Care

# Care Transitions: CMS National Readmission Project

- **Nationally:** 14 target areas with QIOs as lead
  - 1.1 million Medicare beneficiaries
  - 70 hospitals
  - 227 skilled nursing facilities
  - 316 home health agencies

- **Florida**: FMQAI lead for Miami-Dade county
  - 60,000 Medicare beneficiaries
  - 11 hospitals
  - 45 skilled nursing facilities
  - 12 home health agencies
  - Nutrition mgt. & post-discharge meals – Dept. Elder Affairs
  - Community Living Program funds
  - Alliance for Aging (AAA)

# Care Transitions: CMS National Readmission Project



# Care Transitions: Program Outcomes

| | Community / Population Rate | PASS® Coached Rate (Intervention) | Non-Coached Rate |
|---|---|---|---|
| Hospital 1 | 20.26% | **8.76% (N=186)** | 23.26% (N=45) |
| Health Plan 1 | 17.25% | **10.15% (N=8282)** | 13.60% |
| CMS (Overall) | 23.10% | **14.50% (N=945)** | 24.8% (N=339) |
| CMS (DOES – Nutrition) | 23.10% | **7.6% (N=237)** | 13.62% (N=57) |
| CMS (AoA – CLP) | 23.10% | 0% (N=27) | N/A |
| **Other Benefits** | | | |
| Reduction in SNF Utilization (transfers; discharges to SNF) | | | 26% |
| Reduction in Rx Cost / Utilization | | | 36% |

# Care Transitions: PASS®

## Core Pillars

- Medication Management
- Nutrition Management
- Personal Health Record
- Physician Follow-Up
- Red Flags Signs & Symptoms
- Home & Community Based Services

## Patient Readmission Risk Assessment

- Clinical
- Social
- Primary Care & Outpatient Care
- Discharge Planning & Coordination

## Care Transition Care Plan Management

- Care Plan Creation
- Care Plan Review
- Care Plan Management
- Provider Outreach & Coordination

## Reporting & Analysis

- Evaluation of Care Effectiveness
- HEDIS Measures / STARS Measures
- Patient Empowerment
- Inter-disciplinary Team

# Care Transitions – PASS®

- Contracted to provide PASS® with four major health plans including Medicare, commercial and Medicaid members in three states.
- Contracted to provide PASS® with one major hospital system.
- PASS® teams active daily in over 30 hospitals.
- Developing ability to reach diverse populations and geographic areas through contracts with aging network service providers to provide coaching.

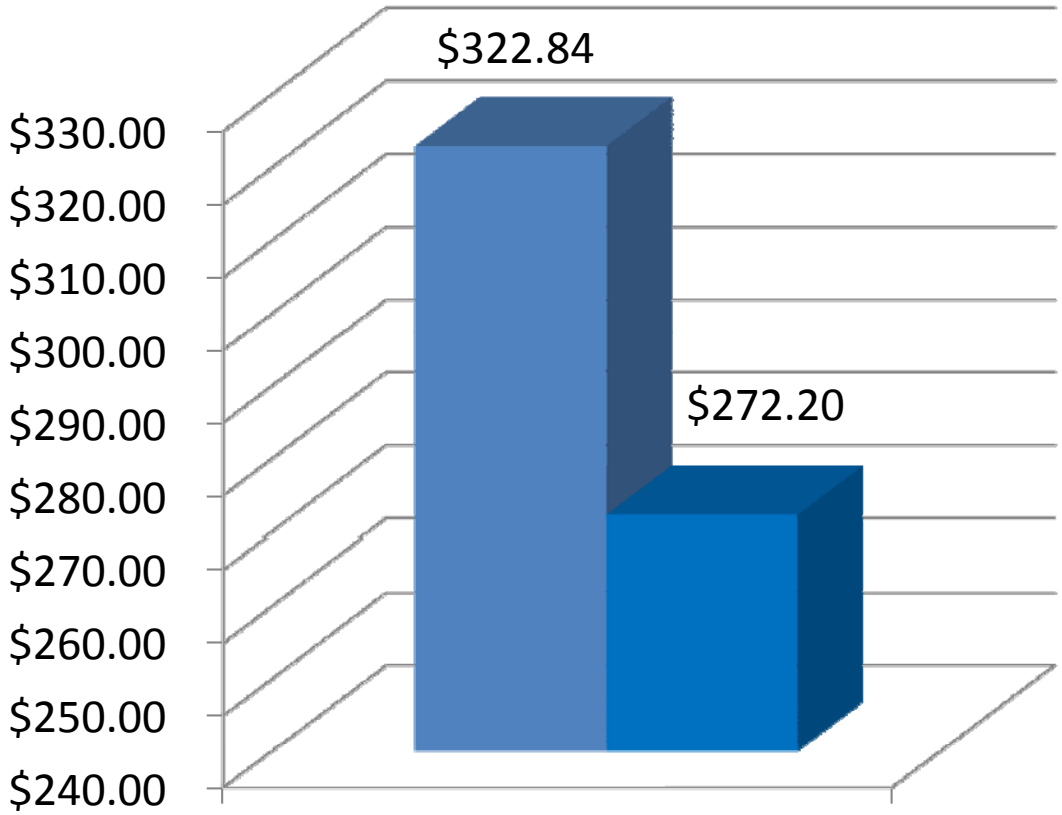
# ILS' Complete Care Management™

- It was originally designed over 10 years ago to manage long-term care populations through the continuum of care, across multiple providers for Florida's nursing home diversion program (Medicaid Waivers).
- The programs were enhanced in 2009 to meet the CMS requirements for all Medicare Advantage (MA) Special Needs Plans (SNP). These requirements include:
  - Comprehensive annual assessments
  - Risk stratification
  - Care plan development
  - Management of ongoing interventions
  - Interdisciplinary team approach
  - Extensive reporting
- The programs have been expanded to meet the needs of Medicare, Medicaid, SPD/ABD, Commercial and long term care members plans.

# ILS' Complete Care Management™

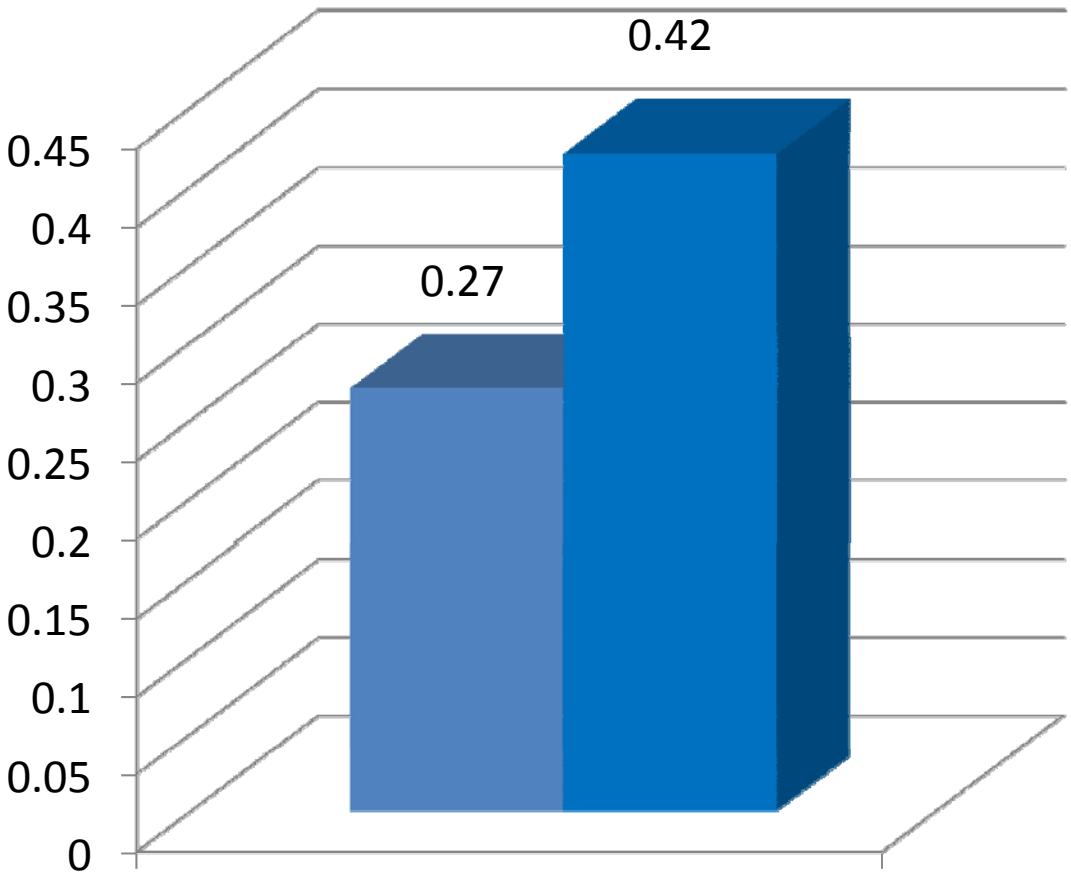
- Currently providing care management support to high risk populations enrolled in five Medicare SNP plans serving nearly 30,000 beneficiaries
  - Reduction in claims costs
  - Reduction in medical loss ratio (MLR)
  - An estimated savings of $4.00 for every $1.00 spent on the intervention
  - Establishes compliant Care Model (HCQA, CMS, etc.)

# Complete Care Management™: Outcomes




**SNP Population Medical Cost PMPM* (N=12492)**

# Complete Care Management™: Outcomes




**PCP Visits PMPM (N=12492)**

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- Josefina Carbonell – *Senior Vice President LTC & Nutrition*

# The LIFT Wellness Program: Preliminary Results from a National Falls Prevention Demonstration Program

## Presented by:


## Marc A. Cohen, Ph.D.

**Chief Research and Development Officer**

**LifePlans, Inc**

# Purpose of the Presentation

- Describe the development of a multi-factorial Falls Prevention program
- Report on the implementation of a national demonstration of the intervention with two LTC insurers:
  - Bankers Life and Casualty
  - John Hancock
- Provide preliminary results of program impacts

# Fall Facts

- 30% - 40% of adults age 65+ fall annually
- 5%-6% of hospital stays are due to fall related injuries and 8% of individuals 70+ treated in emergency rooms due to fall
- 10% to 15% of falls result in fractures
- Falls are leading cause of injury deaths
- In 2020, the cost of fall injuries is expected to reach $43.8 billion

**Majority of falls occur at home and are <u>preventable</u>**
**77% occur while doing daily activities**

# Cost of Falls

- A recent study of people aged 72 and older found that the average health care cost of a fall injury was $19,440 (including hospital, nursing home, emergency room, and home health care, but not physician services);

- The total cost of all fall injuries for people age 65 or older in 1994 was $27.3 billion. By 2020, the cost of fall injuries is expected to reach $43.8 billion

# Implications for LTC Insurers

- Falls are a leading claim cause for institutional and home-based care.
- Well-targeted fall prevention programs can have a significant impact on:
  - Financial performance of claim block.
  - Customer satisfaction through focus on maintenance of safe environment and independent living.
  - Marketing and sales through product differentiation.

# LifePlan's Effort in this Area

- Since 2003 worked with DHHS support to:
  - Review existing fall literature.
  - Interview and evaluate existing Fall Prevention Programs.
  - Convene a prestigious Technical Advisory Group (TAG), and had 2 meetings.
  - Develop a model Fall Prevention Program designed to measure the impact of fall prevention interventions.
  - Develop the procedures, protocols and instruments for conducting the assessment and individually-tailored intervention.
  - Select and work with 2 LTC Carriers to implement demonstration project.

# Project History

- Phase I: (2003-2004) Technical Proposal and Literature Review
- Phase II: (2005-2006) Fall Prevention Program Design
- Phase III: (2007) Fall Prevention Program Pilot
- Phase IV: (2008+) Fall Prevention Demonstration

# The Demonstration Phase:

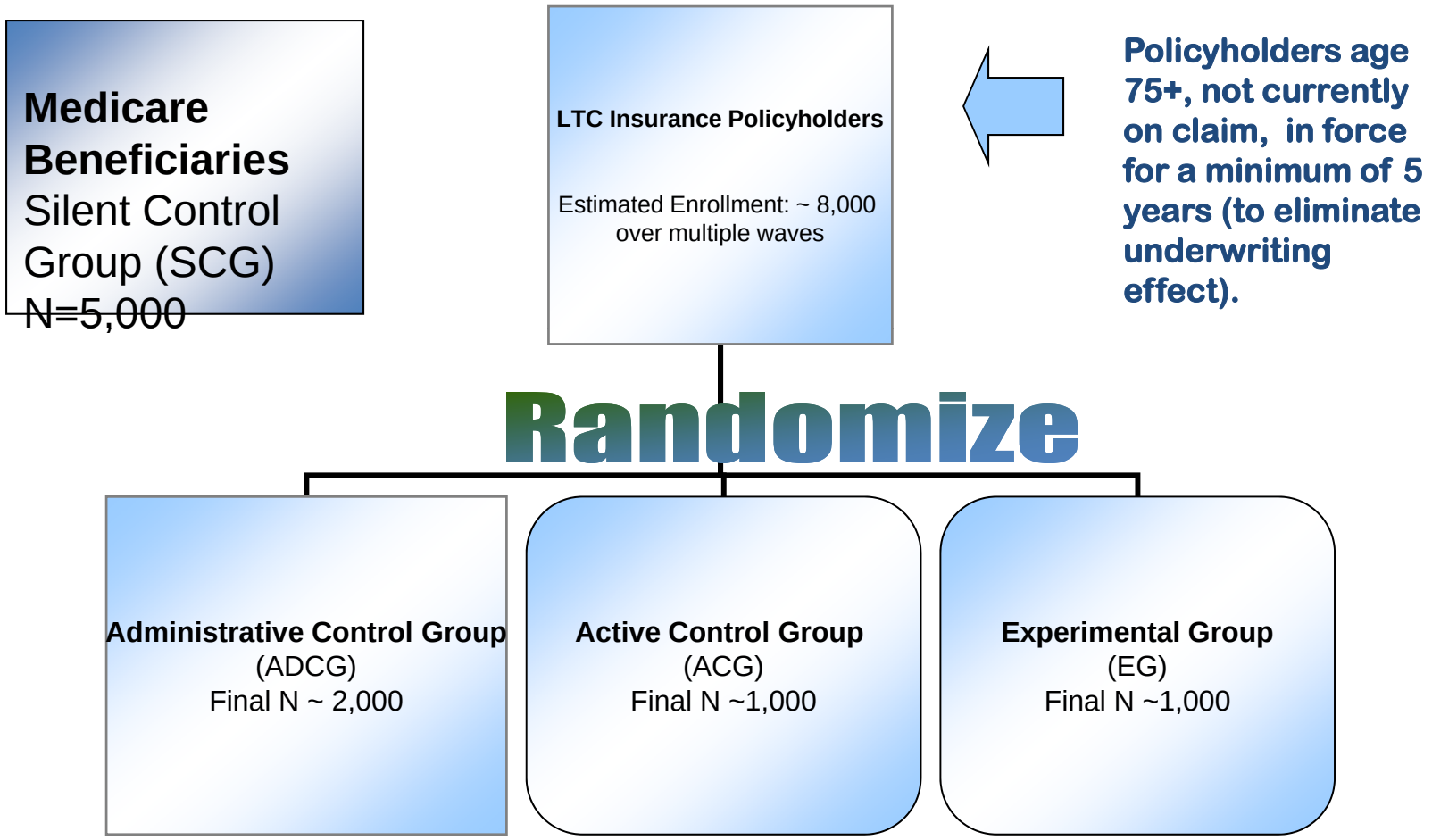
LIFT

*The Wellness Program*

# Demonstration Plan

- Program positioned as a “Wellness” initiative called LIFT Wellness Program.
- **LIFT** stands for **L**iving **I**ndependently and **F**alls-free **T**ogether.
- Enrolling older LTC policyholders into program from John Hancock and Bankers
  - 6,191 total enrollees
    - 2,283 Experimental Group
    - 2,170 Control Group
    - 1,738 Administrative Control group

# Sampling Plan



# Sample Randomization

- Enrollees are randomized into 3 sample groups:
  - **Experimental Group (EG)** receives:
    - Initial Telephone Screen
    - In-Person Assessment;
    - Individualized Action Plan and LIFT Wellness Toolkit
    - Jump Start phone call for action plan implementation
    - Quarterly telephone follow-up
  - **Active Control Group (ACG)** receives:
    - Initial Telephone Screen
    - Quarterly telephone follow-up
  - **Administrative Control Group (ADCG)**
    - Followed through collection of Medicare and LTC claims utilization

# Impacts Studied

- **Incidence of falls**
- **Use of long-term care services**
  - Home health care, Assisted living and Nursing home care
- **Use of acute care services**
  - Emergency room visits, Surgeries, Hospitalizations
- **Reduction in risk factors**
  - Medication management
  - Home safety (i.e, clutter, lighting, loose cords)
  - Fear of falling

# The Intervention:

LIFT

## In Action

# Key Program Components

- **Assessment**
  - Telephone screen to secure baseline information for both experimental group and active control group.
  - In-person evaluations for experimental group at baseline and at program conclusion.
  - Telephone screen at conclusion to determine changes in profile for active control group
- **Intervention**
  - Health promotion and fall prevention tool-kit (LIFT Wellness Tool Kit)
  - Development of customized action plan
  - Development of Physician Summary with medication review
  - Exercise Program
  - Home safety and other service recommendations when needed
- **On-going data collection**
  - Quarterly telephone interviews with EG and ACG
  - Linked LTC insurer's claim and Medicare claim data.

# LIFT Wellness Toolkit

- Components of the kit include:
  - Health and Home Safety Information Pamphlet;
  - Wipe-off Medication Management Planner;
  - NIA Exercise Video and Book;
  - Exercise Progress Charts and Fall Journals;
  - Pedometer

**The Toolkit is designed to assist in program retention, encourage exercise, help with medication compliance and provide education about home safety and fall prevention.**

# "Jump Start" the Intervention

- Two weeks after receipt of Action Plan, follow-up phone call to:
  - Review information contained in the Action Plan;
  - Review of the LIFT Toolkit;
  - Review of next steps to implement Intervention;
  - Encourage participant to contact their Physician to review the results of the assessment;
  - Encourage participant to use NIA exercise video and complete Exercise Progress Chart and Falls Journal;
  - The Participant told they will be contacted on a quarterly basis to check progress.

# LIFT Enrollment as of February 2011

| | Admin Control Group ADCG | Experimental Group EG | Active Control Group ACG | Total |
|---|---|---|---|---|
| Participants Enrolled | 1,738 | 2,283 | 2,170 | 6,191 |
| Phone History Interview | 0 | 2,074 | 2,000 | 4,074 |
| In-Home Evaluation | 0 | 1,771 | 0 | 1,771 |
| Action Plan & Welcome Kit | 0 | 1,771 | 0 | 1,771 |
| Jump Start Interview | 0 | 1,659 | 0 | 1,659 |
| Q1 Follow Up | 0 | 1,193 | 1,281 | 2,474 |
| Q2 Follow Up | 0 | 1,148 | 1,238 | 2,386 |
| Q3 Folllow Up | 0 | 1,127 | 1,204 | 2,331 |
| Q4 Follow Up | 0 | 954 | 1,136 | 2,090 |
| Q5 Follow Up | 0 | 550 | 583 | 1,133 |
| Q6 Follow Up | 0 | 421 | 493 | 914 |
| Q7 Follow Up | 0 | 316 | 327 | 643 |
| Final Phone Inteview - ACG | 0 | 0 | 298 | 298 |
| Final In-Home Evaluation - EG | 0 | 193 | 0 | 193 |

*Recruitment and Interviews are still in progress*

*Participants are from John Hancock and Bankers*

# Preliminary Program Results

LIFT

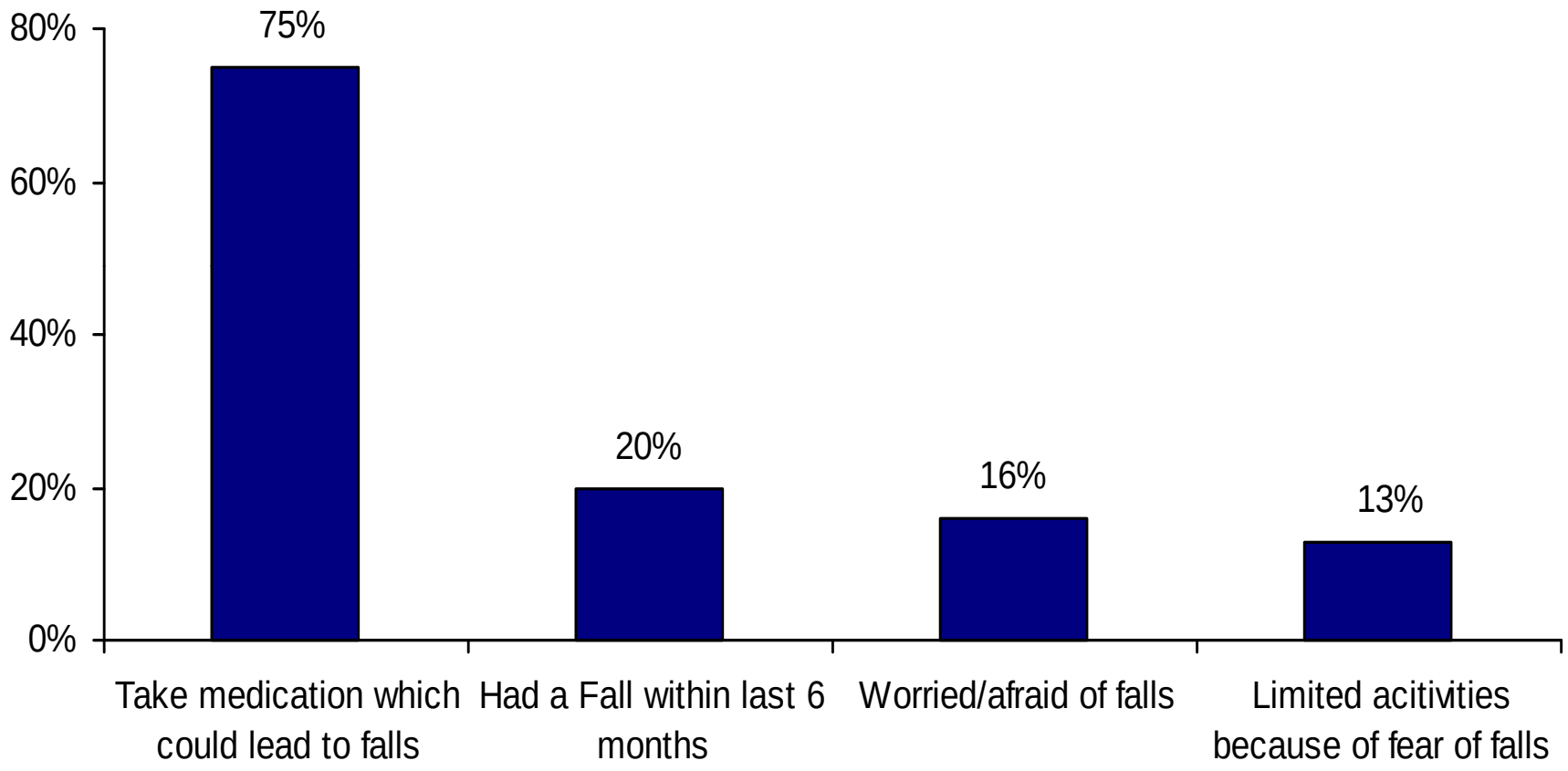
*The Wellness Program*

# Demographics of Sample Groups

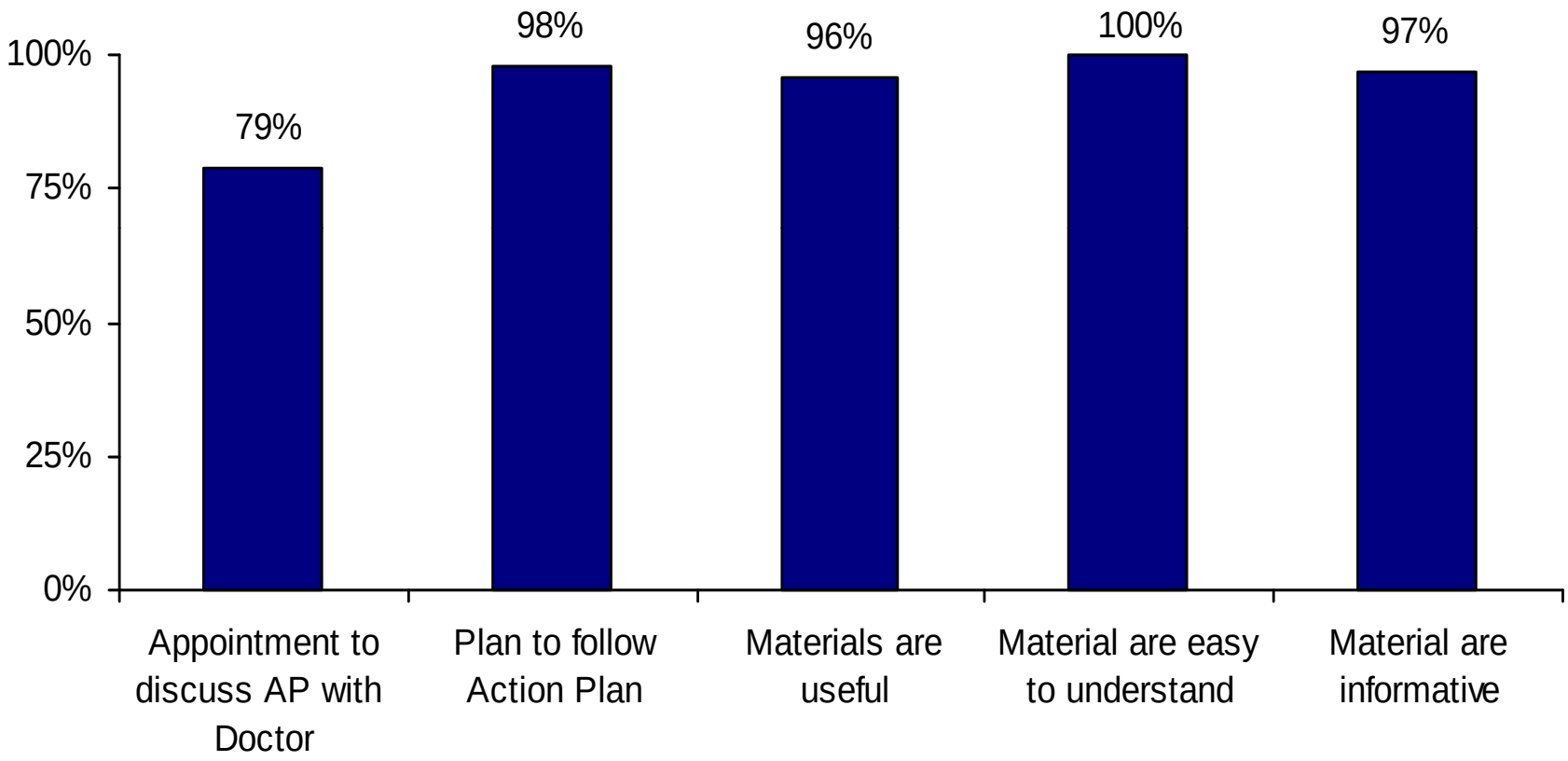
| Baseline Demographics | Active Control Group | Experimental group |
|---|---|---|
| Average age | **81** | **81** |
| % Female | **59%** | **62%** |
| % Married | **60%** | **59%** |
| % with incomes less than $50,000 | **51%** | **50%** |
| % with 1 or more falls | **20%** | **20%** |
| % with no ADL limitation | **95%** | **96%** |
| % with no IADL limitation | **88%** | **85%** |

No significant difference on any variable

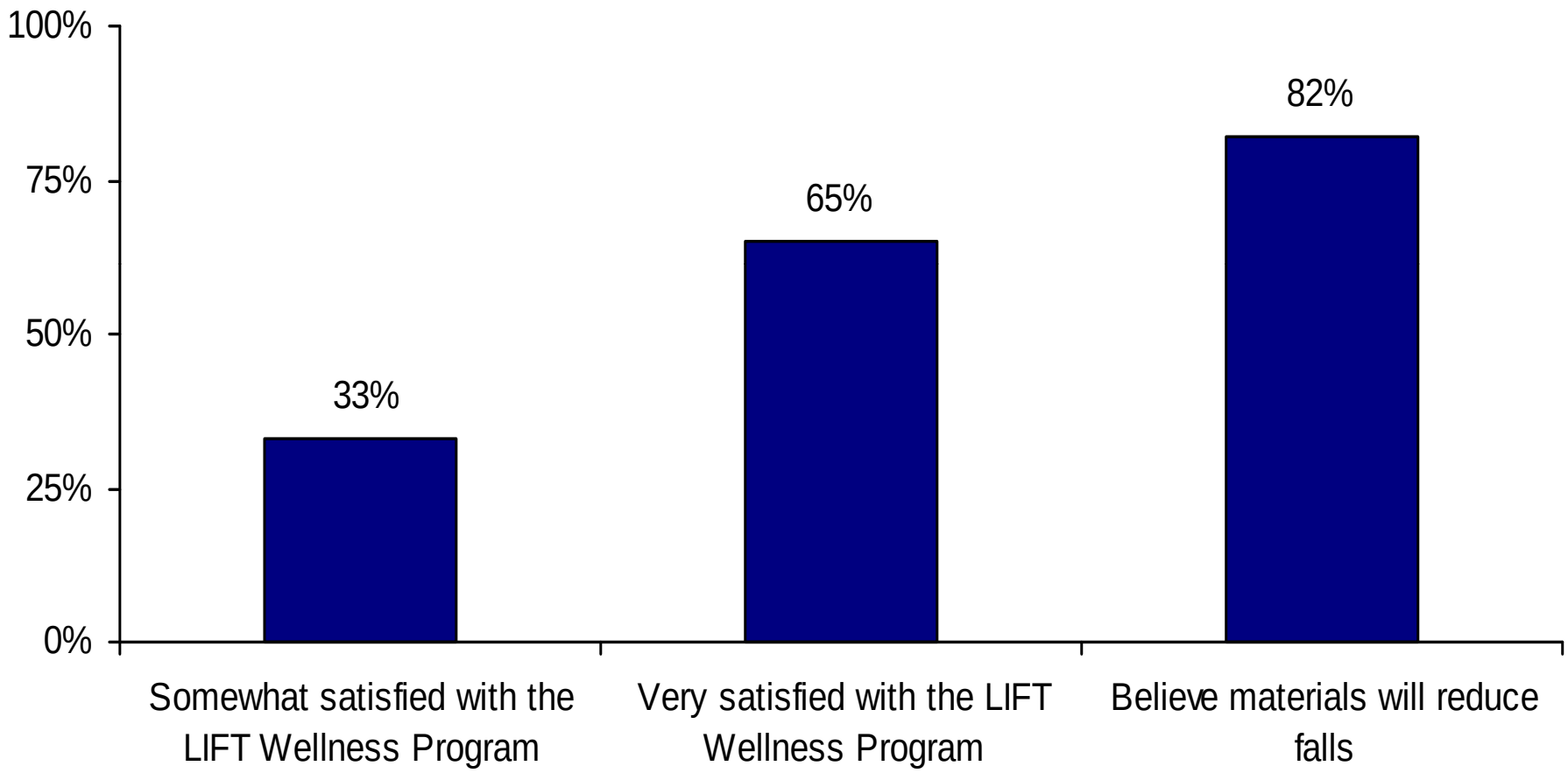
# Baseline Evaluation of Fall Risk Factors (EG)



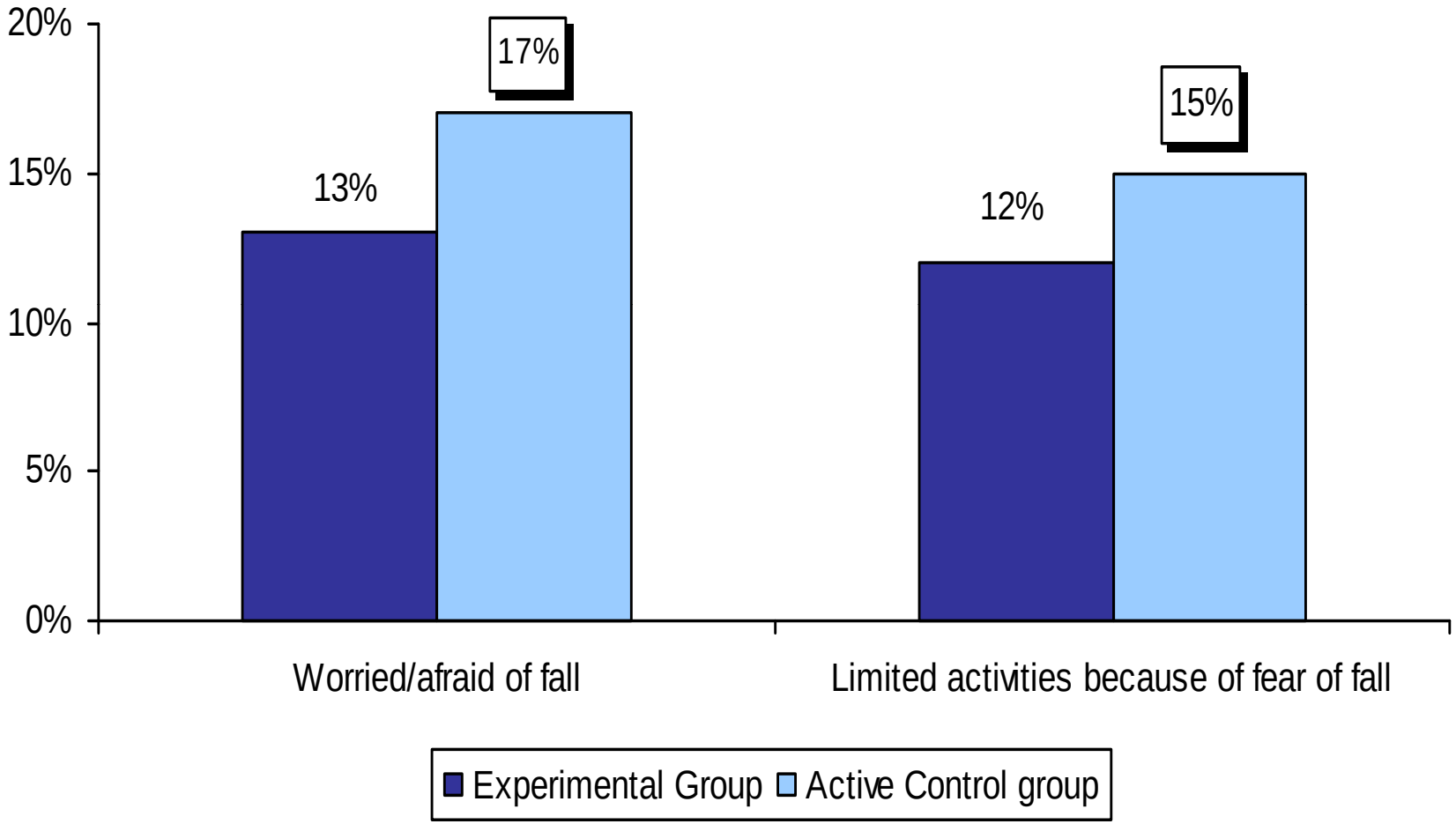
# Evaluation of Action Plan Materials (EG)



# Evaluation of The Program

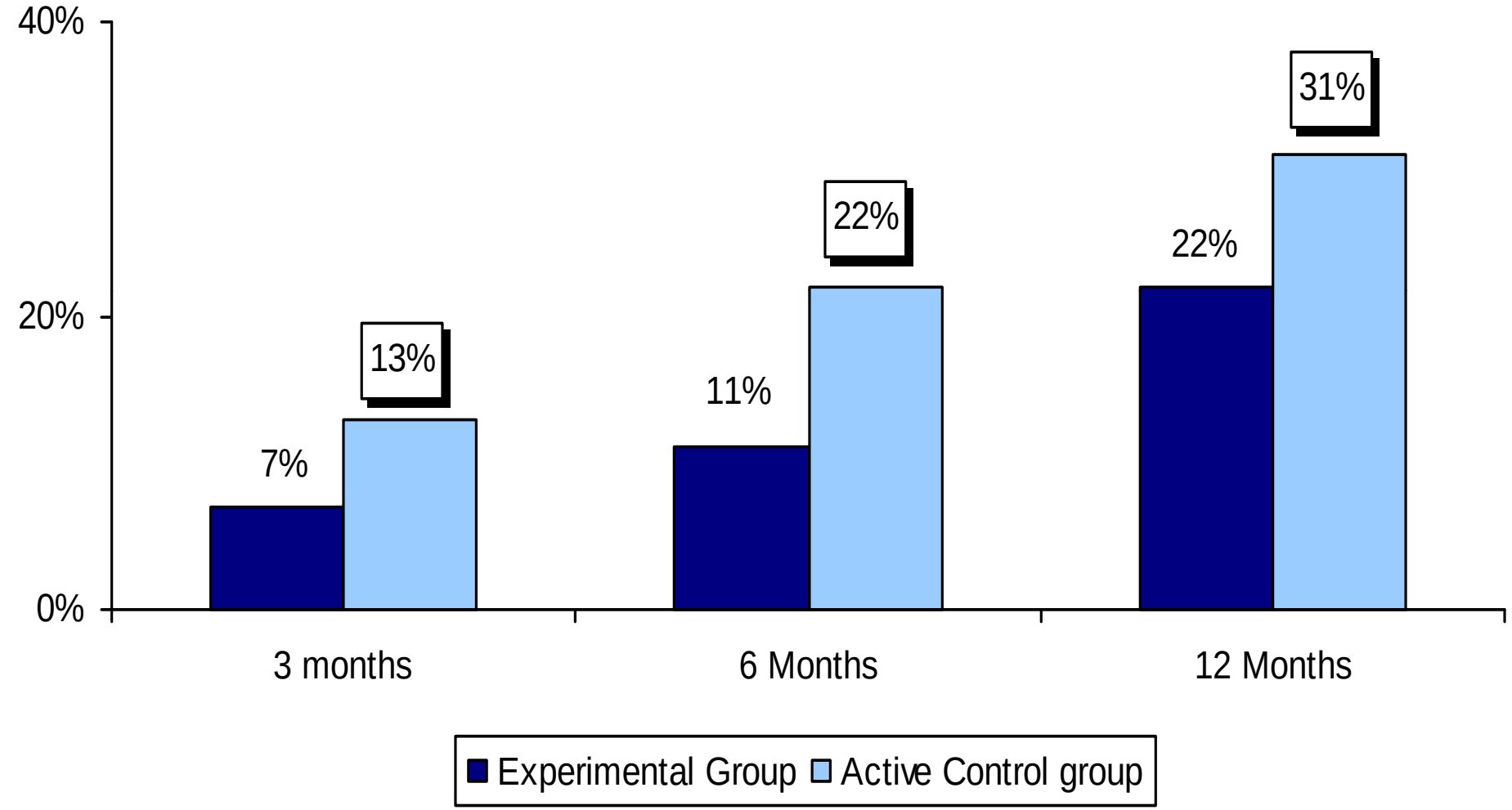


# Concern About Falls
## (3 month Follow-up)



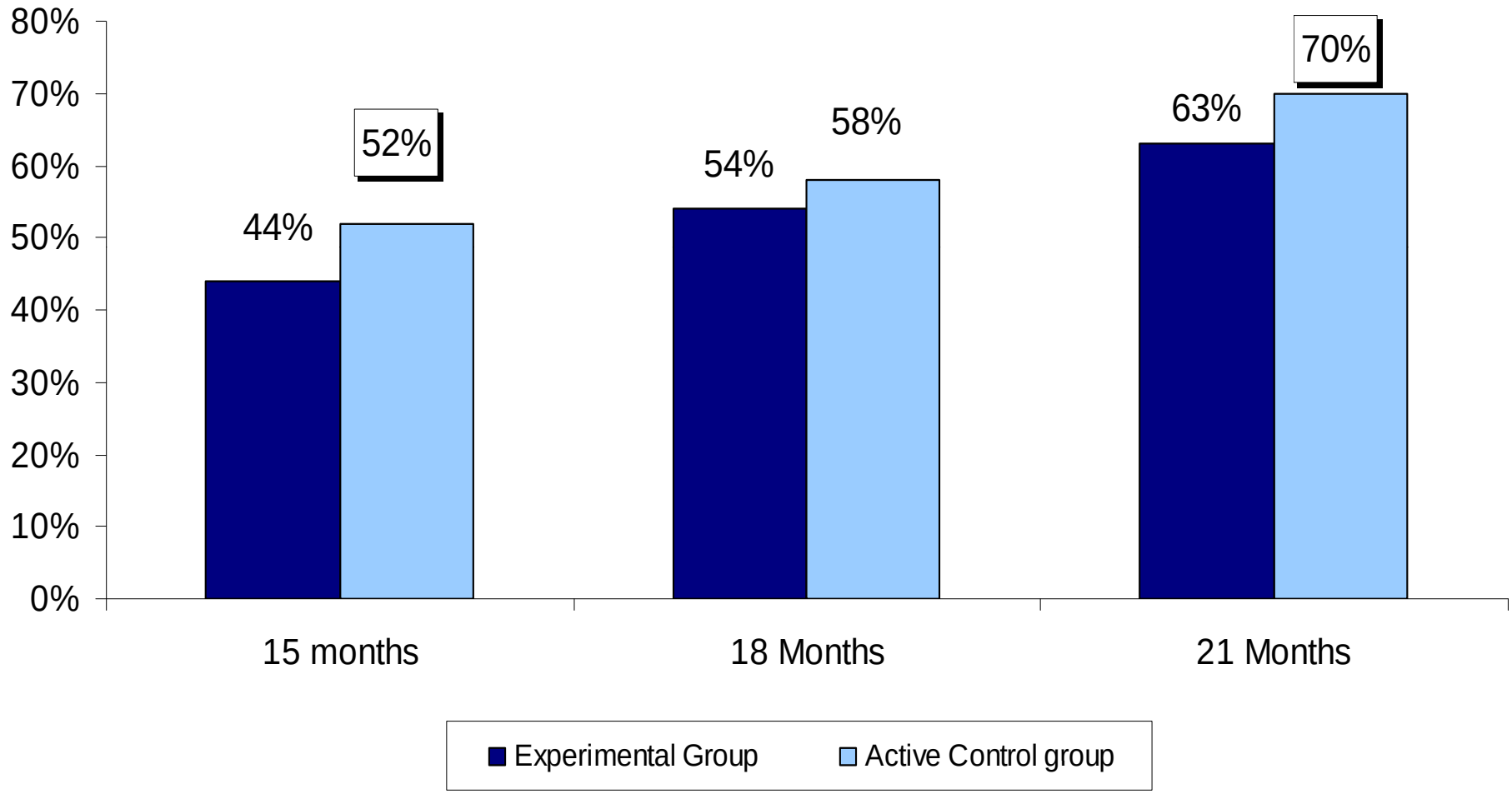

*Represents statistical difference, p=0.05*

# Self Reported Falls Experience
## (3, 6 and 12 months)

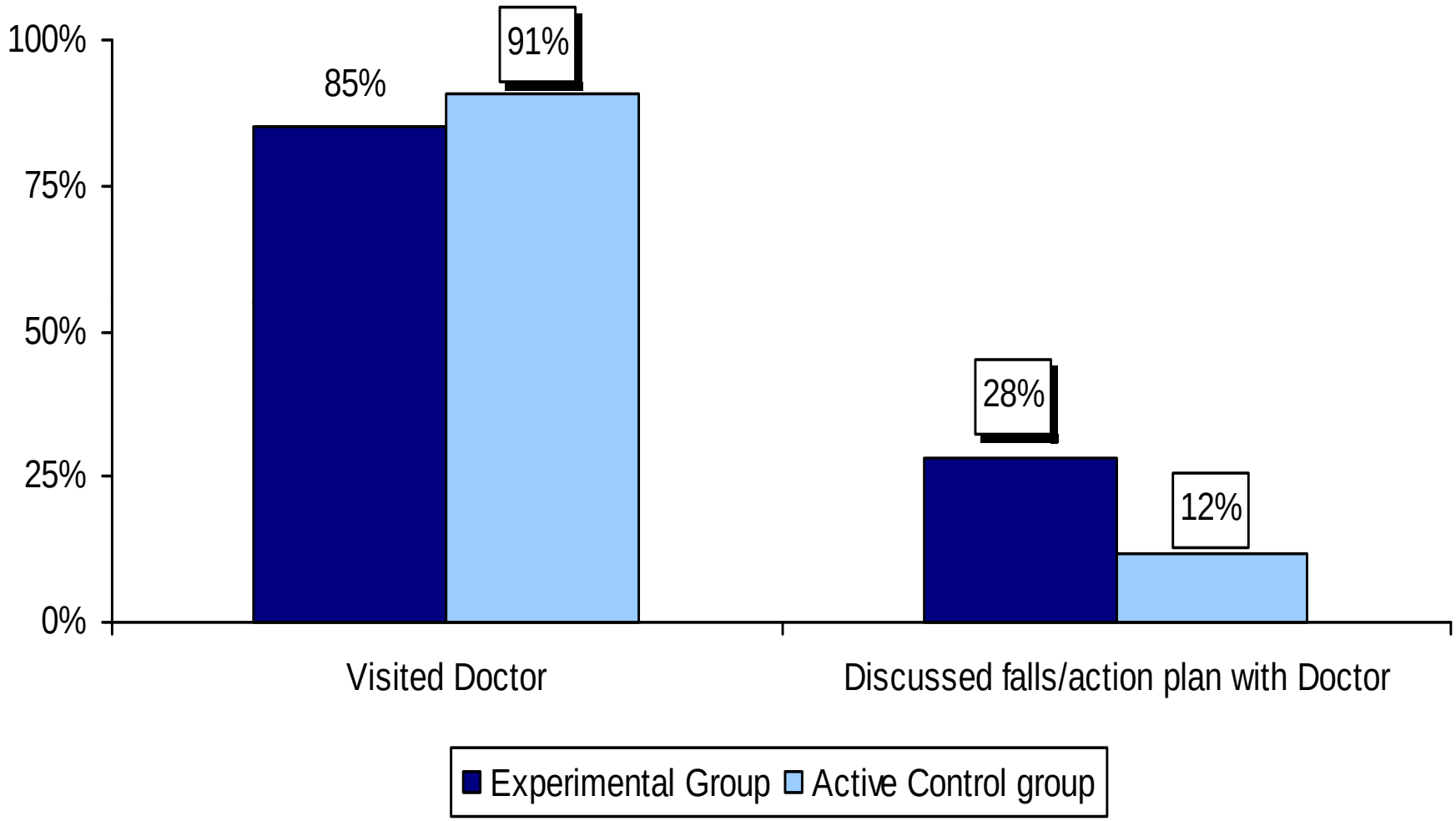



*Represents statistical difference, p=0.05*

# Self Reported Falls Experience
## (15, 18 and 21 months)



# Physician Engagement

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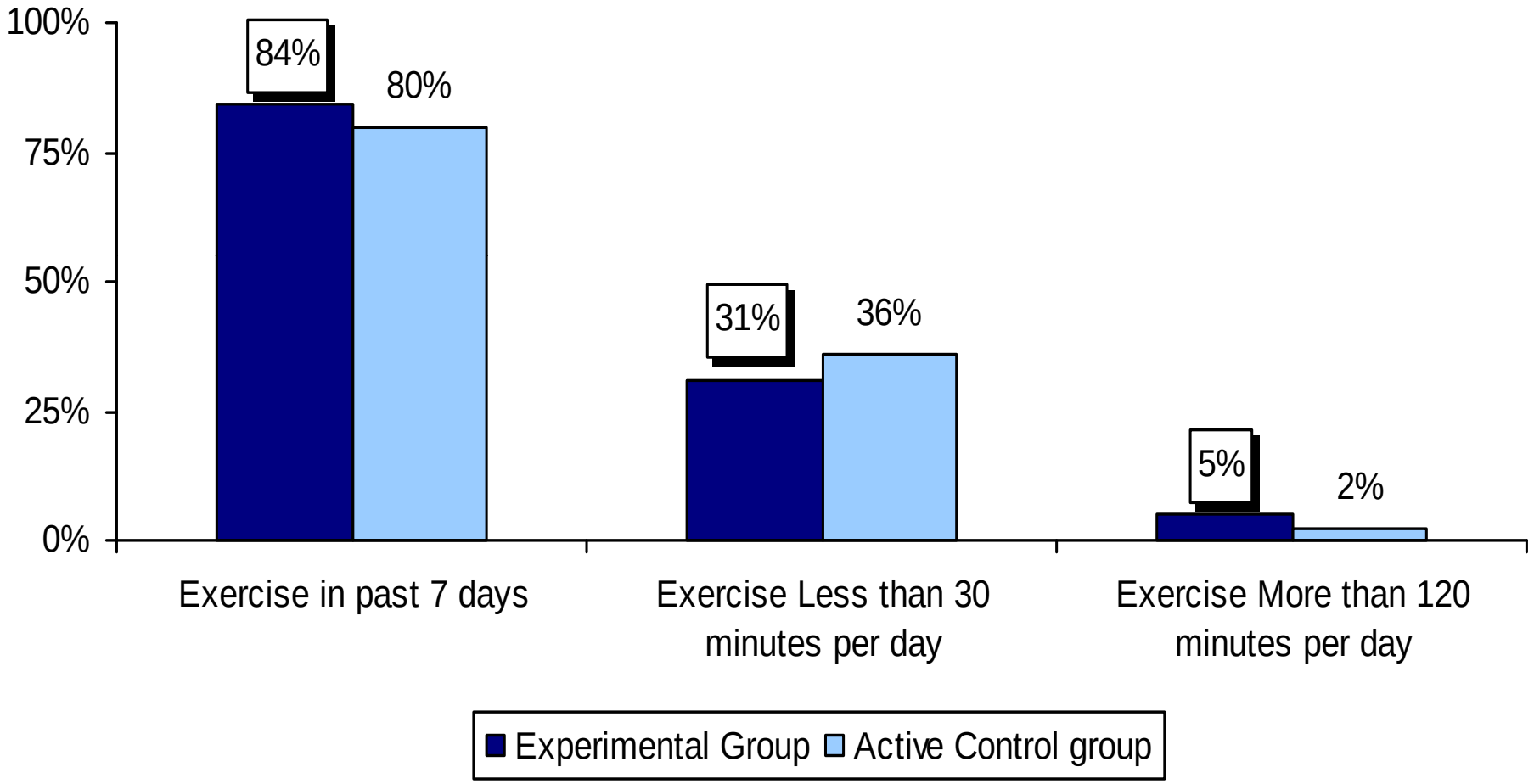
# Changes in Risk Factors
## (6 month Follow-up)



# Changes in Risk Factors
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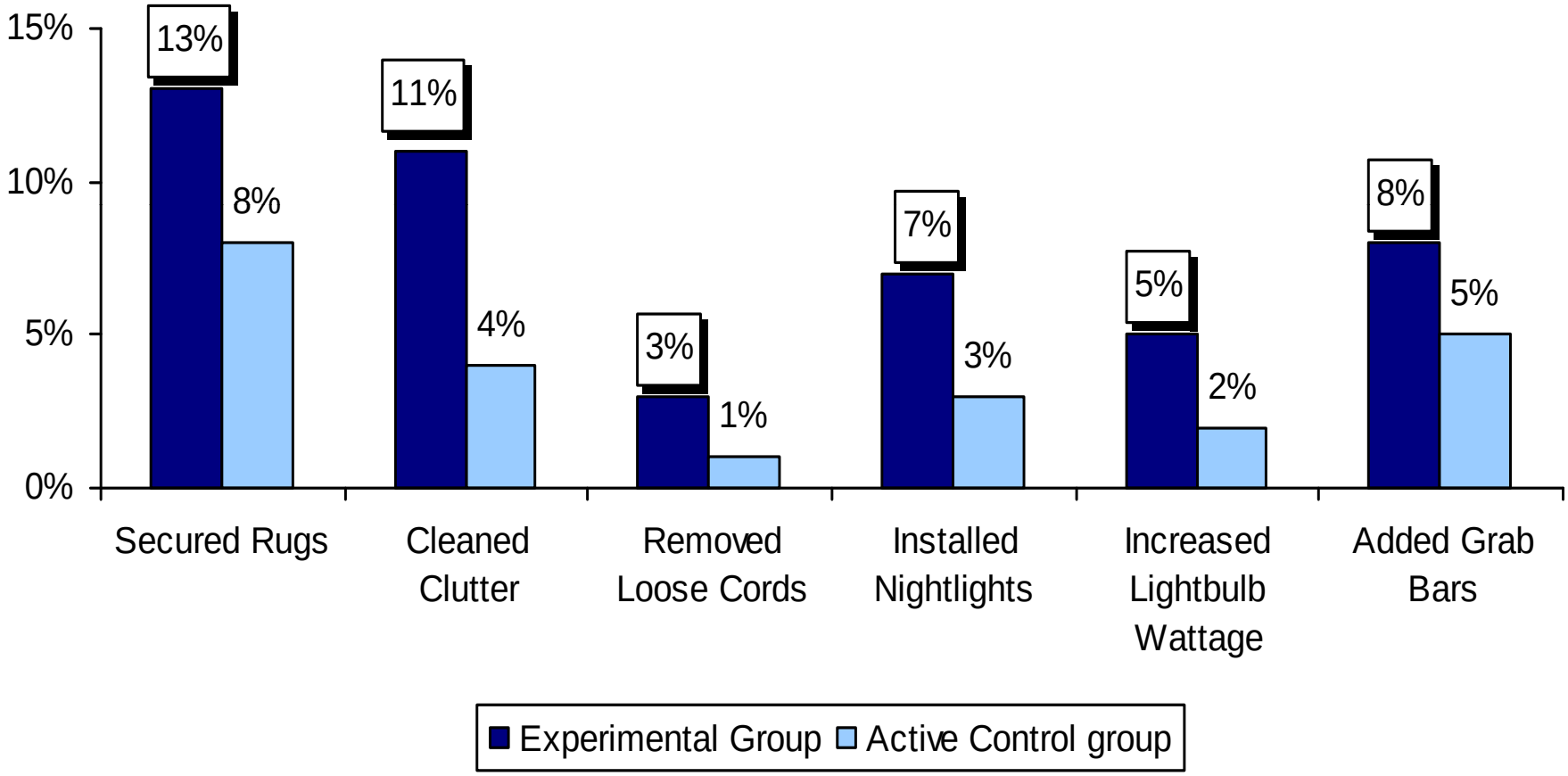
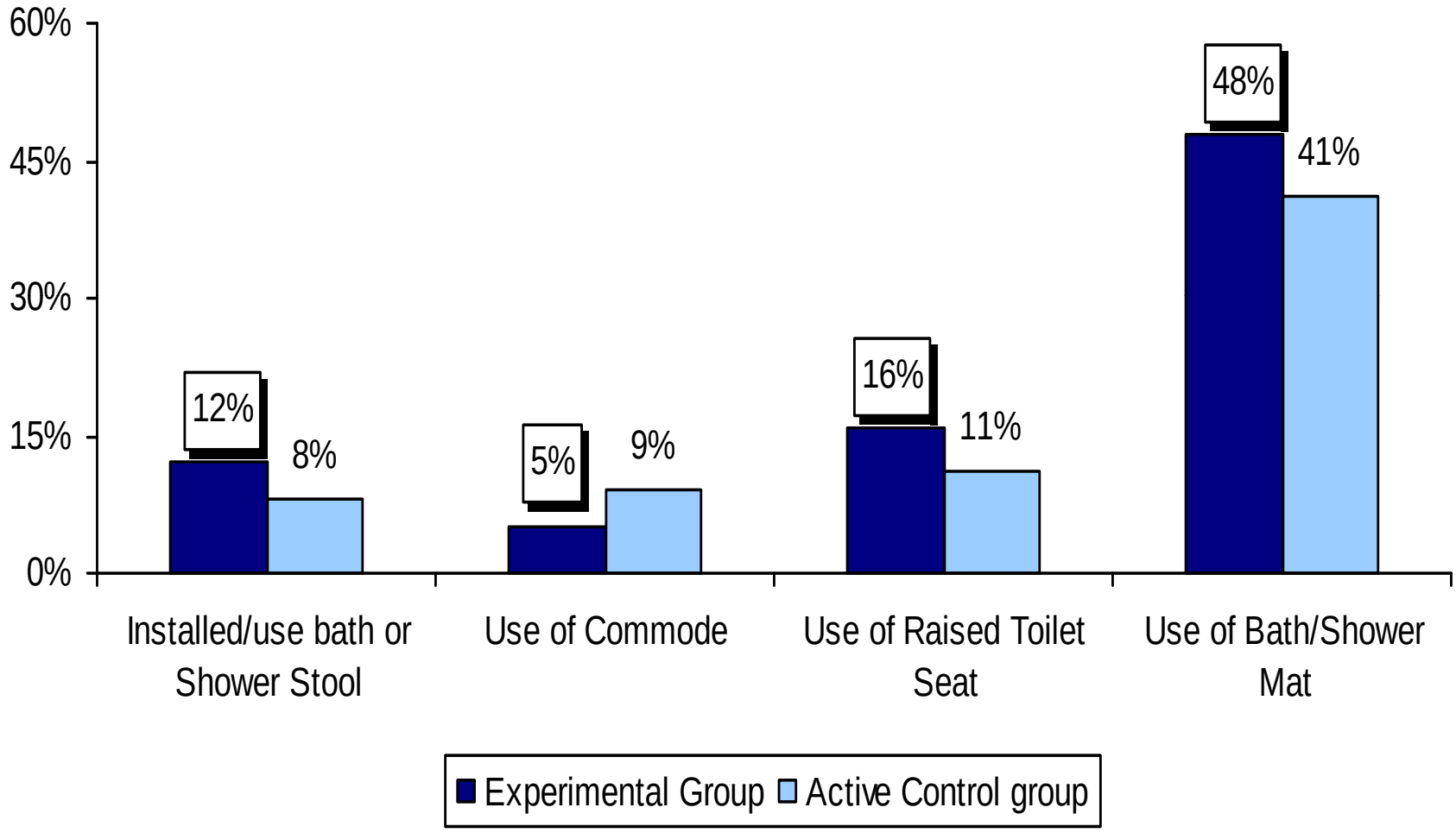



*Represents statistical difference, p=0.05*

# Change in Equipment Use to Mitigate Risks




*Represents statistical difference, p=0.05*

# LTC Claims Data Preliminary Results

- Incidence rate of less than 2% for average exposure of 12 months
  - Do not have linked claims data from both companies
  - 28 claims of which 16 are from the Control Groups and 12 from the Experimental Group

- Sample is too small and not yet enough exposure time to draw meaningful conclusions of program impacts on LTC claims.
  - With additional sample and exposure time should be able to detect statistically significant differences if they exist.

# Summary of Preliminary Results

- Self-reported fall rates have dropped by 50% at six months and by 29% at 12 months.
  - Intervention impact declines over time but still large and significant
- Risk factors have declined for the Intervention Group
  - Fear of falling
  - Limitation on activities due to the fear of falls
- There is general satisfaction with the program which can assist companies on their customer satisfaction scores

# Next Steps

- Final wave to be recruited in 2nd quarter of 2011.
- Begin to look at more comprehensive linkages of LTC claims data and Medicare data to obtain utilization and cost results.
- More detailed analysis of LTC claims data when linkages are complete.

# Thank You

- Project Sponsor
  - Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Aging, Disability and Long-Term Care Policy
- Participating LTC Insurers
  - Bankers Life and Casualty
  - John Hancock