Caring for the Elder in the Practice of Law

Presented for the Southern Arizona Estate Planning Council

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[1] The PowerPoint slides used in this presentation were prepared in part by the Pan American Health Organization for the Central American Diabetes Initiative (CAMDI) (Managua, Nicaragua, July 2-3, 2007).

I. The Problem: Chronic Illness Care in the U.S.

Introduction

- More than a quarter of all Americans and two out of three older Americans suffer from multiple chronic conditions.
- One-third of U.S. health care budget ($1 trillion+ annually) is spent on this population. Among health care costs for older Americans, 95% is spent on chronic diseases.[2]
- Despite advances in care and increased spending, more than half of patients still don't receive appropriate care.
- Our health care system is structured primarily to deliver acute care.

A. The Patient/Care Receiver

Unhealthy Older People (UnHOPs)

Functional limitations

Relates to the individual's ability to care for himself and for his property

or Impaired decision-making

Relates to the individual's ability to make decisions for himself pertaining to his good health, safety, well-being, and quality of life

or Both

Issues Faced by UnHOPs

What UnHOPs Want

- "How do I maintain my autonomy and independence?"
- "How do I manage my chronic illness successfully without burdening others?"
- "How do I find, get, and pay for good care?"

What UnHOPs discover about their chronic care needs

- As they age, their needs for more LTSS increase.
- Some need LTSS some of the time; some need LTSS all of the time.
- UnHOPs often do not get LTSS when they need it; some get LTSS that they do not need.
- UnHOPs are expected to understand on their own the LTSS they need, figure out for

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[2] The State of Aging & Health in America 2013 Report (U.S. Dept. of HHS, National Center for Chronic Disease Prevention and Health Promotion [CDC] 2013).

themselves how to access it, and figure out how to pay for it.[3]

What UnHOPs usually get

- 15-minute doctor visit, poorly organized
- Symptoms and lab results are the focus of discussion and exam, not preventive assessment
- Patient's attempts to discuss difficulties in living with the chronic condition are discouraged
- Focus is on physician's treatment, not patient's role in management
- Treatment plan is limited to prescription refill and encouragement to make appointment if not feeling well
- Patient does not want to question doctor, otherwise will be labeled "difficult"
- Visit ends with physician rifling through drawers looking for a pamphlet[4]

> The current "care system" provides disjointed specialty services, ignores the challenges of living with disabilities, tolerates routine errors in medications and transitions, disdains individual preferences, and provides little support for paid or volunteer caregivers. This maladapted service delivery system now generates about half the lifetime costs for health care services, yet patients and families are left fearful and disoriented, with pain, discomfort, and distress. (JAMA 2013)

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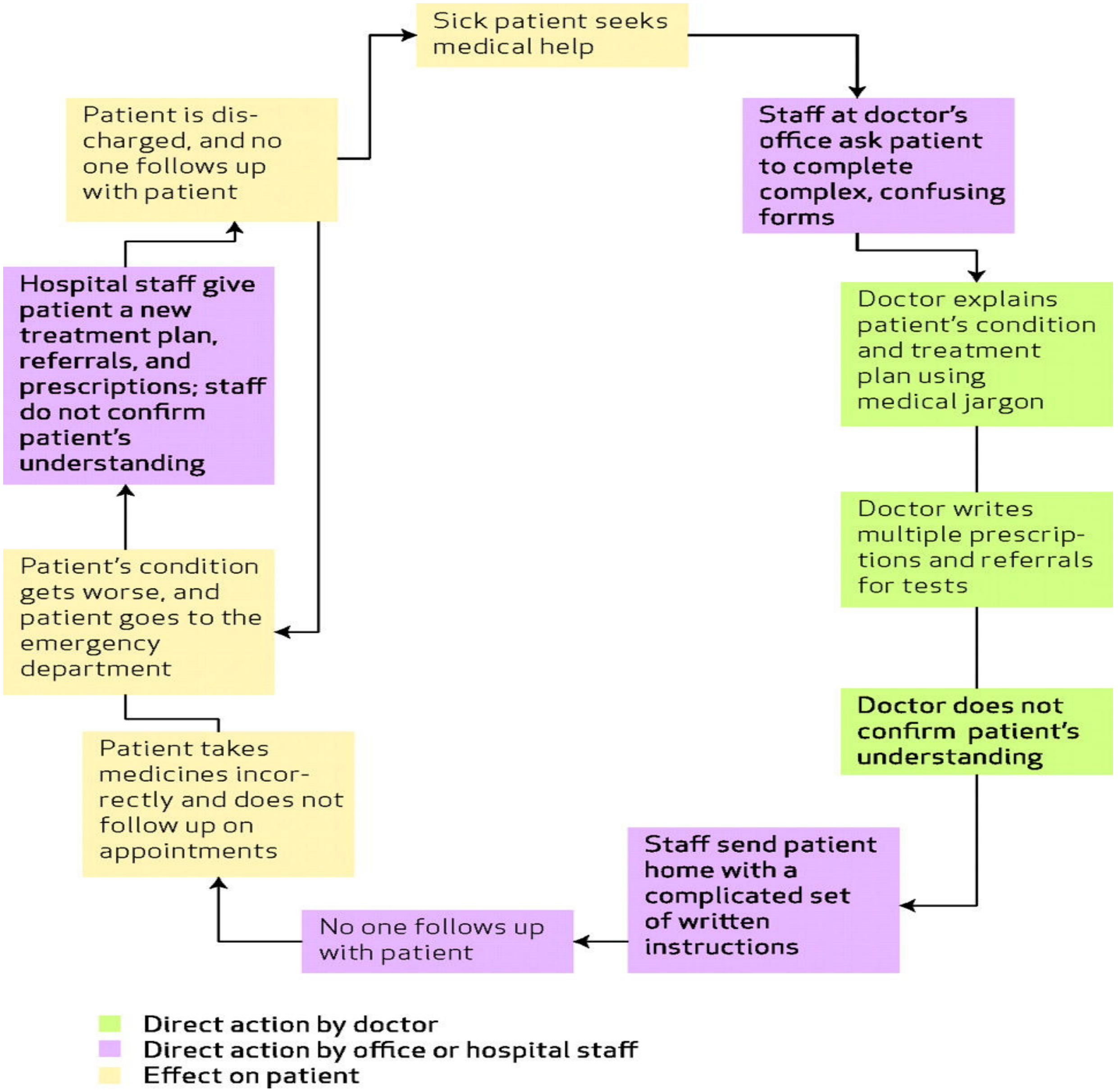
[3] Robert L. Kane & Rosalie A. Kane, *What Older People Want from Long-Term Care, and How They Can Get It*, Health Affairs 2001:22(6) 114-127.

[4] Joanne Lynn, *Reliable and Sustainable Comprehensive Care for Frail Elderly People*, JAMA 2013;310(18):1935-1936 (Nov. 13, 2013).

B. The Cycle of Crisis Care[5]



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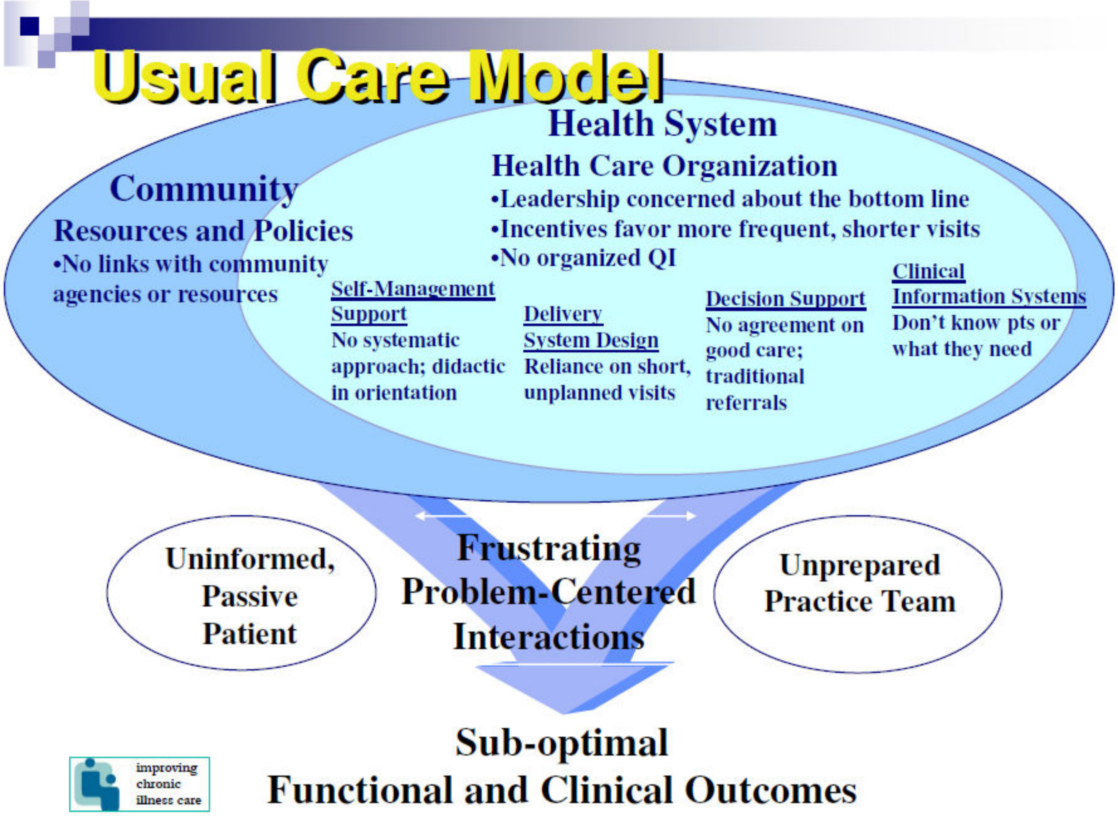
[5] H.K. Koh et al., *New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly "crisis care,"* Health Affairs 2012:31:434-443.

C. The Usual Care Model



Usual Care Model

Health System

Community

Resources and Policies

- No links with community agencies or resources

Health Care Organization

- Leadership concerned about the bottom line
- Incentives favor more frequent, shorter visits
- No organized QI

Self-Management Support
No systematic approach; didactic in orientation

Delivery System Design
Reliance on short, unplanned visits

Decision Support
No agreement on good care; traditional referrals

Clinical Information Systems
Don't know pts or what they need

II. Fixing the Problem: Changing Systems

A. What Patients Need: A Continuous Healing Relationship

A "continuous healing relationship" with a care team and practice system organized to meet their needs for:

- Effective treatment (clinical, behavioral, supportive),
- Information and support for their self-management,
- Systematic follow-up and assessment tailored to clinical severity,
- More intensive management for those not meeting targets, and
- Coordination of care across settings and professionals.

B. What Must Be Done: Reform of the Health Care Delivery System

Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others.

Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible, to evolve from acute-focused "find it and fix it" health care systems toward ones that are proactive, provide comprehensive and coordinated care, and are designed to meet the long-term needs of patients.[6]

> **Trying harder will not work. Current health systems cannot do the job. Changing care systems will.**
>
> **-- U.S. Institute of Medicine (2001)**

C. The Chronic Care Model[7]

The Center for Health Studies has developed the Chronic Care Model[8]—a guide to

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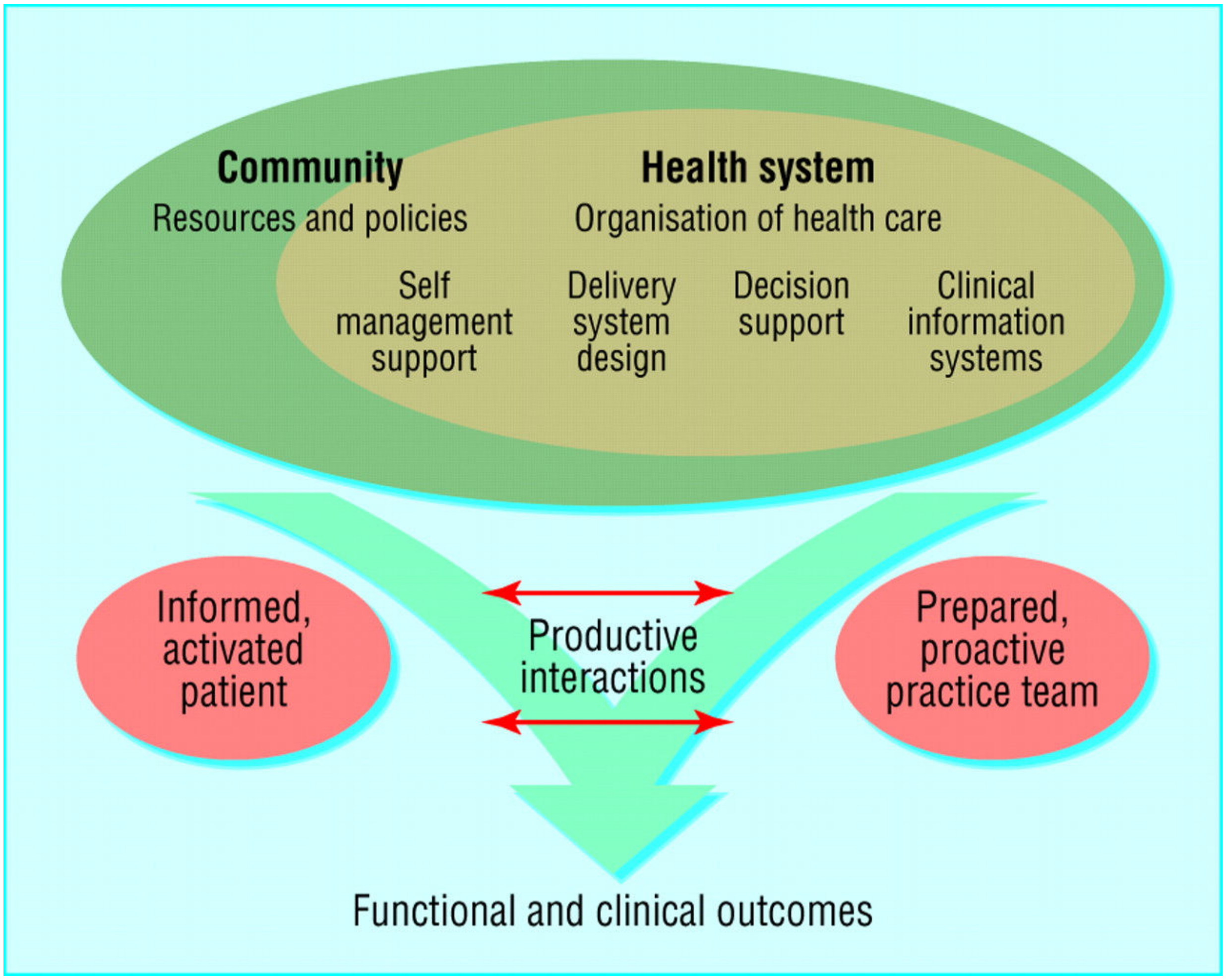
[6] *Crossing the Quality Chasm: A New Health System for the 21st Century* (U.S. Institute of Medicine 2001) (available at http://books.nap.edu/openbook.php?record_id=10027).

[7] *See* Improving Chronic Illness Care (ICIC) program of the Robert Wood Johnson Foundation, http://www.improvingchroniccare.org.

[8] The Chronic Care Model was developed by Dr. Edward H. Wagner at the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, and leader of ICIC. *See* Edward H. Wagner, *Improving Chronic Illness Care: Translating Evidence into Action*, Health Affairs (Nov/Dec 2001); and Edward H. Wagner, *Chronic disease management: What will it take to improve care for chronic illness?*,

chronic care improvement—that is useful to diverse health care organizations wanting to improve the care of their patients with chronic illness.

Critical to improving chronic care outcomes is engaging the "informed, activated patient" to promote better self-management of chronic illness. As described in the Chronic Care Model (below), an informed, activated patient is one who has the motivation, information, skills, and confidence necessary to make decisions about his health and manage it.



Six Focal Areas[9]

1. Health Care Organizations
2. Community Resources and Policies
3. Self-Management Support
4. Decision Support

Effective Clinical Practice 1998;1:2-4, at http://www.acponline.org/journals/ecp/augsep98/cdm.htm. Image used by permission of ACP-ASIM Journals and Books, which holds the copyright.

[9] For a summary of each of these six focal areas, *see* Improving Chronic Illness Care, *Resource Library, Steps for Improvement (1): Models*, http://www.improvingchroniccare.org/index.php?p=1:_Models&s=363 (accessed Feb. 19, 2016).

5. Delivery System Design
6. Clinical Information Systems

The “Prepared, Proactive, Practice Team”

The goal of the Chronic Care Model is “promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health settings.” This goal is accomplished through “productive interactions” between a “prepared, proactive practice team” and an “informed, activated patient,” which in turn will lead to improved health outcomes.

The Chronic Care Model was developed to promote integrated change with components directed at the following:

- Influencing provider behavior;
- Better use of non-physician team members;
- Enhancement of information systems;
- Planned encounters (interactions linked through time to achieve specific goals);
- Patient self-management; and
- Modern self-management support.[10]

The “Informed, Activated Patient”

The informed, activated patient is a critical component to improving outcomes in engaging with the “prepared, proactive practice team.”

Patients provide the majority of their own care in the day-to-day management of their chronic illnesses.

Necessity for an informed, activated patient: patient education. But, Dr. Wagner says, patient education doesn’t exist. If it did, more patients would demand higher quality of chronic illness care.

Dr. Wagner: “With appropriate public and consumer education, we can get consumers to be more demanding of high quality care, and become thereby, collectively, change agents. At the moment, they are non-players in this quality consideration. But they should be: they are the ones with the greatest stake in the game. But they will need further education.”[11]

D. The Triple Aim

Extensive research documents the impact of social factors such as income, educational attainment, access to food and housing, and employment status on the health and longevity of Americans, particularly lower-income populations. These findings attribute as much as 40 percent of health outcomes to social and economic factors. Thus, asthma is linked to living conditions, diabetes-related hospital admissions to food insecurity, and greater use of the emergency room to homelessness.[12]

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[10] Ruth Ballweg et al., *Physician Assistant: A Guide to Clinical Practice, 5th Ed.*, 172 (Elsevier Health Sciences 2012).

[11] Edward H. Wagner, *Part 8: Improving the Care of the Chronically Ill*, 2004 Epidemiology, Biostatistics and Clinical Research Methods Summer Session co-sponsored by the Seattle Veterans Affairs Epidemiologic Research and Information Center (ERIC) and the University of Washington, http://www.improvingchroniccare.org/index.php?p=Chronic_Illness_Care_Lecture_Series&s=1196 (accessed Feb. 19, 2016).

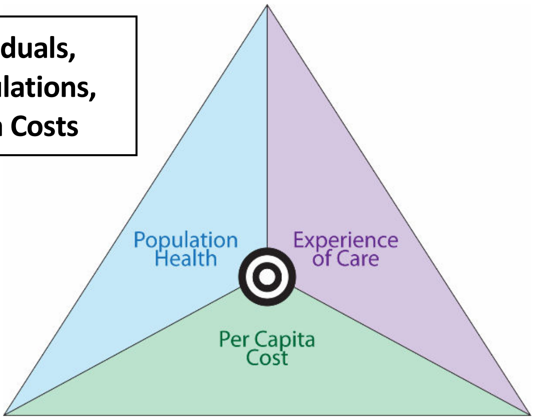
[12] Deborah Bachrach et al., *Addressing Patients’ Social Needs: An Emerging Business Case for Provider*

A framework developed in 2008 by the Institute for Healthcare Improvement, the Triple Aim describes an approach to optimizing health system performance in which new designs are developed to simultaneously pursue three dimensions, which IHI calls the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.[13]

Six years after IHI introduced the concept of the "Triple Aim," these three goals have become the organizing framework for the health care system.

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs



Informed by the Triple Aim, public and private payers are introducing payment models that hold providers financially accountable for overall patient health and the costs of treatment. These models—such as bundled payments and other innovative financing approaches, accountable care organizations and other shared savings arrangements, and sanctions for avoidable events such as penalties for hospital readmissions—give providers economic incentives to incorporate social interventions into their approach to care.

E. HHS Initiative on Multiple Chronic Conditions

The U.S. Department of Health and Human Services administers a large number of federal programs directed toward the prevention and management of multiple chronic conditions (MCC). HHS also provides leadership in improving health outcomes in individuals with MCC.

- Multiple Chronic Conditions: A Strategic Framework
- Inventory of Multiple Chronic Conditions Activities: Database of Programs, Tools, and Research Initiatives to Address the Needs of Individuals with Multiple Chronic Conditions
- Multiple Chronic Conditions Among Medicare Beneficiaries
- Chronic Conditions
- Co-Morbidity
- Chronic Conditions Chart Book
- Chronic Conditions Dashboard
- Chronic Conditions Maps and Charts
- Multiple Chronic Conditions Measurement Framework

Investment (Commonwealth Fund May 2014) (available at http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs).

[13] Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, Health Affairs 27(3):759–69 (May/June 2008); Institute for Healthcare Improvement, *The IHI Triple Aim*, http://www.ihi.org/Engage/Initiatives/TripleAim/ (accessed Feb. 19, 2016).

- MCC Research Network[14]

F. Medicare Chronic Care Initiatives

The Affordable Care Act (ACA) created several Medicare initiatives that promise to improve care coordination and transitional care for beneficiaries with chronic conditions, including the following:

- HHS Partnership for Patients
- Medicare Community-based Care Transitions Program
- Post-discharge Transitional Care Management
- Medicare Hospital Readmission Reduction Program
- Home Health Services for Caregivers of Alzheimer's Patients
- Medicare Independence at Home Demonstration
- Patient-Centered Medical Homes (Advanced Primary Care Practices)
- CMS Innovation Center Initiatives – Testing Medicare Models for Chronic Care Coordination[15]

Medicare Payment for Chronic Care Management in 2015

Effective January 1, 2015, Medicare began to reimburse physicians and certain other providers for furnishing "chronic care management" services to beneficiaries with multiple chronic conditions. Physicians can bill for chronic care management services using new Current Procedural Terminology (CPT) code 99490, which has the following description:

> Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

What does this mean? Historically, Medicare has not paid separately for care management services delivered outside of a physician's face-to-face encounter with a patient, such as telephone check-ins with nurse care managers. Beginning in 2015, Medicare will provide separate reimbursement under the Part B Physician Fee Schedule to physicians and eligible non-physician practitioners for furnishing certain types of non-face-to-face care management services to beneficiaries with multiple chronic conditions.

CMS describes various services that are considered to be within the scope of chronic care management, including:

- the provision of 24-hour-a-day, 7-day-a-week access to healthcare providers to address the patient's acute chronic care needs;
- continuity of care with a designated practitioner or member of the care team;
- various care management activities, including: the systematic assessment of the patient's medical, functional, and psychosocial needs; approaches to ensure the patient's timely receipt of preventive care services; medication reconciliation, with a

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[14] U.S. Dept. of HHS, Office of the Asst. Secy. for Health, *Initiatives, Multiple Chronic Conditions*, http://www.hhs.gov/ash/initiatives/mcc/ (updated Oct. 18, 2015).

[15] Keith D. Lind, *Recent Medicare Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions*, Fact Sheet (AARP Public Policy Institute March 2013).

review of adherence and potential medication interactions; and oversight of the patient's self-management of medications;
- the development of a comprehensive patient-centered plan of care document in consultation with the patient, caregiver, and other key healthcare practitioners treating the patient;
- management of care transitions, including referrals to other clinicians and follow-up care after emergency department visits and hospitalizations;
- coordination with home and community-based clinical service providers; and
- enhanced opportunities for patient-provider communications via telephone, secure messaging, the internet, or other non-face-to-face methods.[16]

Improving Medicare Post-Acute Care Transformation Act (IMPACT)

Hospitals, inpatient rehabilitation facilities and long-term care hospitals, critical access hospitals, and home health agencies are required to develop a discharge plan based on the goals, preferences, and needs of each applicable patient. The Improving Medicare Post-Acute Care Transformation Act of 2014 (commonly called the IMPACT Act) requires that patient assessment data used in post-acute care settings (i.e., skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long term care hospitals) be standardized to improve quality of care.

To facilitate coordinated care and improved beneficiary outcomes, the Act also supports the interoperable exchange of standardized patient assessment data across post-acute care settings and other providers. The Act requires HHS to implement specified clinical assessment categories using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers.[17]

G. VA: Office of Patient Centered Care and Cultural Transformation

In 2010, the U.S. Department of Veterans Affairs established the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) to move VA health care away from being disease-centered ("What is the matter with this patient?") to a patient-centered model of care ("What matters to you?").

OPCC&CT works with VA leadership and health care providers to transform VA's health system to a personalized, proactive, patient-driven model that promotes whole health for veterans and their families.

> **Personalized care** means putting your needs first and partnering with you to create a customized health plan based on your goals, personal history, and lifestyle [says OPCC&CT on its Web site].
>
> **Proactive care** means your care team will actively work with you to find preventive, rather than reactive, options that strengthen your individual, innate capacity for health and healing—for example, using mind-body approaches and nutritional changes prior to surgery or

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[16] 79 Fed. Reg. 67,548, 67,721 (Nov. 13, 2014).

[17] Standardized post-acute care (PAC) assessment date for quality, payment, and discharge planning, 42 U.S.C. § 1395lll(a)-(m). Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, 80 Fed. Reg. 68126 (proposed Nov. 3, 2015) (HHS).

> chemotherapy.
>
> **Patient-driven care** puts you at the head of your personal health care team, so clinicians can give you the skills, resources, and support to drive your own care.[18]

H. Federal-State Initiatives

Medicaid Managed Long-Term Services and Supports

Here's how CMS describes Medicaid Managed Long Terms Services and Supports (MLTSS):

> Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs. Increasing numbers of States are using MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency. The number of States with MLTSS programs increased from 8 in 2004 to 16 in 2012, and CMS has experienced increasing interest from States in the form of concept papers, waiver applications and requests for technical assistance.
>
> MLTSS offers States a broad and flexible set of program design options, and may be used as an overarching structure to promote initiatives such as Money Follows the Person, participant-directed services, the Balancing Incentive Program, etc. States and stakeholders have expressed an interest in learning more about MLTSS, and how new LTSS opportunities in the Affordable Care Act may be incorporated into an MLTSS program.
>
> Medicaid MLTSS programs can be operated under multiple federal Medicaid managed care authorities at the discretion of the state and as approved by CMS, including 1915a, 1915b, and 1115. There are requirements and limitations related to each authority, and managed care authorities can be combined with (as with a concurrent 1915b and, for example).[19]

By 2014, twenty-six states had implemented Medicaid MLTSS.[20]

TennCare

In January 1994 Tennessee moved almost a million Medicaid beneficiaries into TennCare, the state 1115 Medicaid waiver program, that covered virtually all of the state's Medicaid beneficiaries (except for those in long-term care, that is, beneficiaries in nursing homes) into fully capitated managed care plans. Nearly 400,000 others gained eligibility. TennCare was initially celebrated for reducing the percentage of the state's uninsured population to among the lowest in the nation. Financial problems beset the program, as managed care plans exited TennCare and costs increased, leading to a purge in TennCare rolls and a tightening of eligibility.[21]

In 2010, TennCare swallowed the long-term care component of Medicaid that had been

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[18] U.S. Dept. of Veterans Affairs, *Health Care, VA Patient Centered Care, Office of Patient Centered Care and Cultural Transformation: Promoting Whole Health*, http://www.va.gov/PATIENTCENTEREDCARE/about.asp (updated June 3, 2015).

[19] U.S. CMS, *Medicaid.gov, Medicaid, By Topic, Delivery Systems, Medicaid Managed Long Term Services and Supports*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html (accessed Aug. 10, 2015).

[20] See Paul Saucier et al., *The Growth of Managed Care Long-Term Services and Supports (MLTSS) Programs: A 2012 Update* (U.S. CMS July 2012) (available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf).

[21] Marsha Gold & Anna Aizer, *Growing an Industry: How Managed in TennCare's Managed Care?*, Health Affairs 19(1):86-101 (Jan./Feb. 2000).

carved out of the original waiver, becoming one of the first—if not the first—state to privatize its entire Medicaid program into managed care. The LTSS component is called "TennCare CHOICES in Long Term Services and Supports," which for obvious reasons has been abbreviated, and is usually referred to as "CHOICES."

AHCCCS and ALTCS

In July 2011, nearly 90 percent of Medicaid beneficiaries in Arizona were enrolled in managed care. Prior to 1982, Arizona was the only state that did not participate in Medicaid. When it launched the Arizona Health Care Cost Containment System (AHCCCS) that year, Arizona was the first state in the nation to enroll all Medicaid beneficiaries statewide in mandatory managed care. AHCCCS continues to operate on a mandatory basis statewide, and AHCCCS acute care health plans cover acute, primary and specialty services.

Since 1988, AHCCCS has covered both acute care, long term services supports (LTSS), and behavioral health for older adults and individuals with disabilities in need of a nursing home level of care through the Arizona Long Term Care System (ALTCS) program.[22]

On September 30, 2015, Gov. Douglas A. Ducey submitted a request to the U.S. Department of Health & Human Services to apply for a Section 1115 waiver, to cover the period of October 1, 2016, through September 30, 2021. Called "AHCCS CARE," the waiver would change coverage for the Medicaid expansion population to require recipients to make co-payments and seek employment (among other things). The waiver would also impose a five-year lifetime limit on Medicaid benefits for able-bodied adults.[23]

Medicare-Medicaid Managed Care Demonstrations

The Medicare-Medicaid Coordination Office was established pursuant to section 2602 of the Affordable Care Act. This office works with the Medicaid and Medicare programs, across federal agencies, states and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. "We partner with States to develop new care models and improve the way Medicare-Medicaid enrollees receive health care," says CMS.[24]

In 2012 AHCCCS submitted a proposal to CMS to implement a implement a three-year Demonstration with Medicare enrollment effective January 1, 2014, for individuals eligible for both Medicare and Medicaid ("dual-eligibles"). On April 10, 2013, AHCCCS notified CMS that the state was withdrawing its proposal. Instead, AHCCCS planned to improve the system for dual-eligible AHCCCS members through its current managed care model and by greater leveraging of the Medicare Advantage Special Needs Plans for Dual Eligibles.[25]

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[22] U.S. CMS, *Medicaid.gov*, *Medicaid, By State, Arizona,* https://www.medicaid.gov/medicaid-chip-program-information/by-state/arizona.html (accessed Feb. 24, 2016).

[23] Application for a New Section 1115 Demonstration (Arizona Health Care Cost Containment System, Sept. 30, 2015) (available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa2.pdf). *See* Kaiser Family Foundation, *Medicaid, Proposed Changes to Medicaid Expansion in Arizona*, kff.org/medicaid/fact-sheet/proposed-changes-to-medicaid-expansion-in-arizona/ (Nov. 20, 2015).

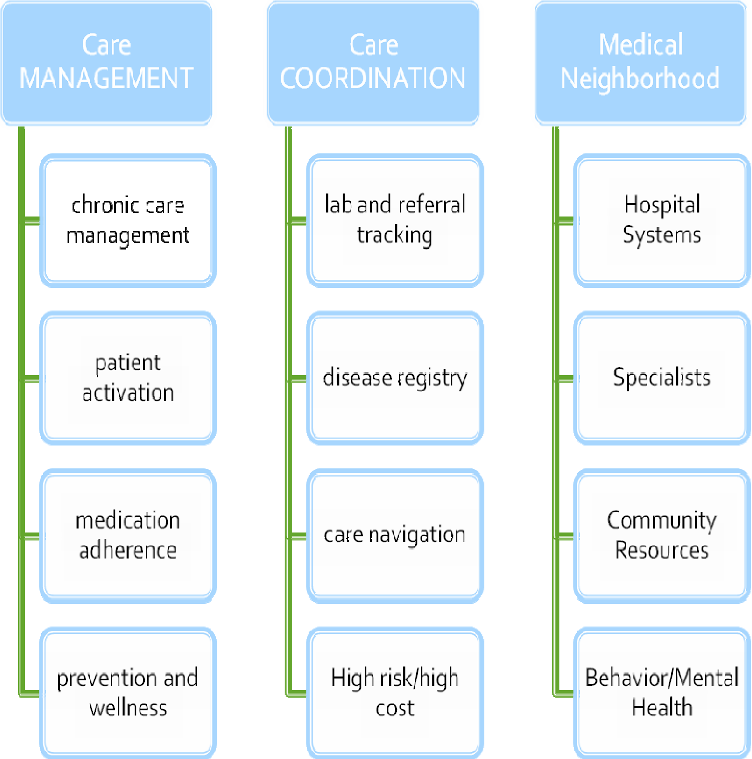
[24] U.S. CMS, *Medicare-Medicaid Coordination, Medicare and Medicaid Coordination Office*, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ (updated Feb. 3, 2016).

[25] AHCCCS, *Initiatives, Care Coordination, Individuals Covered by Both Medicare and Medicaid (Duals)*, https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/duals.html (accessed Feb. 24, 2016)

I. The Patient Centered Medical Home and the Medical Neighborhood

In a Patient Centered Medical Home, a Primary Care Provider (PCP) is responsible for providing “whole person care.” Under this model, the medical provider is challenged to engage an individual in managing more of his or her own care, to make shared decisions about care with that individual, and integrate with specialists and non-medical service providers to support the individual’s efforts. The individual is challenged with knowing how to manage optimum health between office visits and staying out of the hospital.

To be certified as a Patient Centered Medical Home, providers must integrate social supports into their care models. These certifications almost always trigger higher levels of reimbursement. More than 40 states have adopted PCMH programs, providing important funding opportunities for qualified providers.[26]



First introduced by the American Academy of Family Physicians in 1994, the Patient Centered Medical Home (PCMH) appears in the Affordable Care Act of 2010 and is promoted by the U.S. Centers for Medicare & Medicaid Services as a future model for the delivery of care.[27] Other insurance providers and large hospital-based organizations are now testing the model.[28]

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[26] Graphic courtesy of HealthTeamWorks.

[27] *See* U.S. Dept. of HHS, Agency for Healthcare Research and Quality, *Patient Centered Medical Home Resource Center*, http://pcmh.ahrq.gov/ (accessed Feb. 19, 2016).

[28] Recent studies have shown that medical home intervention, which include shared savings for participating practices, are associated with relative improvements in quality, increased primary care utilization, and lower use of emergency department, hospital, and specialty care. Mark W. Friedberg et al., *Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care*, JAMA Int. Med.: doi:10.1001/jamainternmed.2015.2047 (published online June 1, 2015).

Characteristics of the Patient-Centered Medical Home

The Joint Principles of the Patient-Centered Medical Home identifies seven key characteristics:[29]

1. Personal Physician
2. Physician-Directed Medical Care Team
3. Whole Person Care
4. Care is Coordinated/Integrated Across the Health Care System and the Community
5. Quality and Safety are Hallmarks
6. Enhanced Access to Care
7. Payment Recognizes the Added Value to Patients

The Medical Neighborhood

The Medical Neighborhood is an emerging concept meant to address all the care needs of an individual. The Medical Neighborhood, a collaborative group of both non-medical and medical care providers (one of whom may be the Medicare beneficiary's PCMH), will identify and coordinate all resources available to manage issues which impact a patient's health. The aim is to improve clinical outcomes, provide a more satisfying experience of care for both patients and providers, and reduce care costs.

Whereas the Chronic Care Model encourages patients to connect with resources in their communities—such as disease prevention and management professionals—community partnerships in the Medical Neighborhood can broaden these resources to address the social determinants of health. For example, patients can suffer from a number of cultural and social vulnerabilities, such as poor housing, inadequate access to nutritious food, limited transportation, and low levels of formal education. Establishing relationships with nonmedical and literacy organizations can help patients begin to manage these vulnerabilities.[30]

The Medical Neighborhood includes medical specialists, pharmacies, behavioral health, residential care facilities, non-medical home care providers, and other community resources. Working together, this group will educate and guide the individual in the direction of getting all their care needs met. To ensure that the individual receives optimal care, the Medical Neighborhood strives to meet psychosocial needs, address social and environmental factors that impact the individual's health and well-being, and address financial and legal aspects that enhance or create barriers to care.

J. The Elder-Centered Law Practice

Included among the "Specialists" and "Community Resources" in the Medical Neighborhood is the Elder-Centered Law Practice.

Note that to bill Medicare under the new CCM code, physicians must develop and

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A 2009 collaboration between Blue Cross Blue Shield of Michigan and 39 physician organizations laid the foundation in 2013 for the largest state-based PCMH program in the United States—more than 1130 practices representing 3469 physicians. Emeott A. Annis et al., *Four-year evolution of a large, state-wide patient-centered medical home designation in Michigan*, Med. Care 51(9):846-53 (2013).

[29] American Academy of Family Physicians et al., *Joint Principles of the Patient-Centered Medical Home* (Feb. 2007).

[30] H.K. Koh et al., *A Proposed "Health Literate Care Model" Would Constitute a Systems Approach to Improving Patients' Engagement in Care*, Health Affairs 32(2):357-67 (Feb. 2013).

provide to the Medicare beneficiary a "care plan." CMS has identified the following as items typically included in a care plan:

- Problem list; expected outcome and prognosis; measurable treatment goals
- Symptom management and planned interventions (including all recommended preventive care services)
- Community/social services to be accessed
- Plan for care coordination with other providers
- Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management)
- Responsible individual for each intervention
- Requirements for periodic review/revision[31]

The physician (or a licensed clinical staff member) must furnish a minimum of 20 minutes/month of CCM services. In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute requirement:

- performing medication reconciliation and overseeing the beneficiary's self-management of medications;
- ensuring receipt of all recommended preventive services; and
- monitoring the beneficiary's condition (physical, mental, social).

This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of transitional care management, for example, CMS identified the following additional services as non-face-to-face care management services:

- provide education and address questions from patient, family, guardian, and/or caregiver;
- identify and arrange for needed community resources; and
- communicate with home health agencies and other community service providers utilized by the beneficiary.

How would the Elder-Centered Law Practice work with the Patient-Centered Medical Home that has secured beneficiary consent to provide Medicare CCM services?

Irene, 86, a cognitively intact but depressed woman living alone after the death of her husband, who cannot walk more than a few steps safely because of severe arthritis and spinal stenosis, is failing because of poor nutrition and debilitation. Irene's primary care physician is unable to mobilize the mental health, personal assistance, nutritional, and socialization services that could alter the course of her decline.[32]

Irene's children retain the Elder-Centered Law Practice on behalf of their mother to assist them in identifying the resources and benefits that are or could be available or accessible to Irene.

The elder law firm's Elder Care Coordinator visits Irene's PCP to discuss how the firm will assist the physician's care team to develop and monitor an electronic care plan and coordinate with HCBS clinical service providers to meet Irene's psychosocial needs and

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[31] *See* Pershing Yoakley & Associates, PC, *Providing and Billing Medicare for Chronic Care Management* (Nov. 2104, updated March 2015) (available at http://www.pyapc.com/resources/collateral/white-papers/Chronic-Care-Whitepaper-PYA.pdf).

[32] Example based on Robert J. Master & Catherine Eng, *Integrating Acute and Long-Term Care for High-Cost Populations*, Health Affairs 20:6, pp. 161-172 (Nov/Dec 2001).

functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services).[33]

Accordingly, one can envision the physician billing Medicare for its services in working with the Elder-Centered Law Practice that identify and arrange for needed community resources under the CCM care plan.

For example, Irene was recently hospitalized and is scheduled for discharge from a skilled nursing facility. The physician's Physician Assistant (PA) and the Elder Care Coordinator (ECC) develop a care plan for a safe discharge to Irene's home that includes delivery of meals, home health services, non-medical personal care, and medication management. As the care plan is implemented, the PA and the ECC remain in regular communication to monitor the plan and review for changes. The PCP bills Medicare monthly for 20 minutes of CCM services.

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[33] An "electronic care plan," "transitions of care," and "coordination of care" are three of the five CCM capabilities required of the CCM provider.

III. Care Planning Along the Elder Care Continuum

A. Five Principles

1. The Care of an Older Person Can Be Planned

(Thesis)

2. Care Planning Takes Place Across 3 Domains

(Scope)

Legal

Financial

Personal

3. Care Must Be Safe, Effective, Timely, Efficient, Equitable, and Elder-Centered

(Characteristics of Care) (*from* Institute of Medicine, 2001)

4. Fundamental Planning Goal: Find, Get, and Pay for Good Care

5. Care Is a Resource That Must Be Applied Along a Continuum As and When Needed

(This principle informs our methods and procedures.)
"The Rule": Spend what you need to spend today to take care of yourself today.
Corollary: Spend the elder's resources first.

B. Care Planning Domains

Legal		Financial		Personal	
◊●	Estate planning	◊●	Taxation	◊	Access
◊	Surrogate decision-making	◊●	Retirement	◊	Quality
◊	Public benefits	◊●	Asset preservation	◊	Cost
◊	Counseling	◊●	Wealth management	◊	Services & Supports
◊	Advocacy	◊●	Risk management		
		◊●	Liquidity		

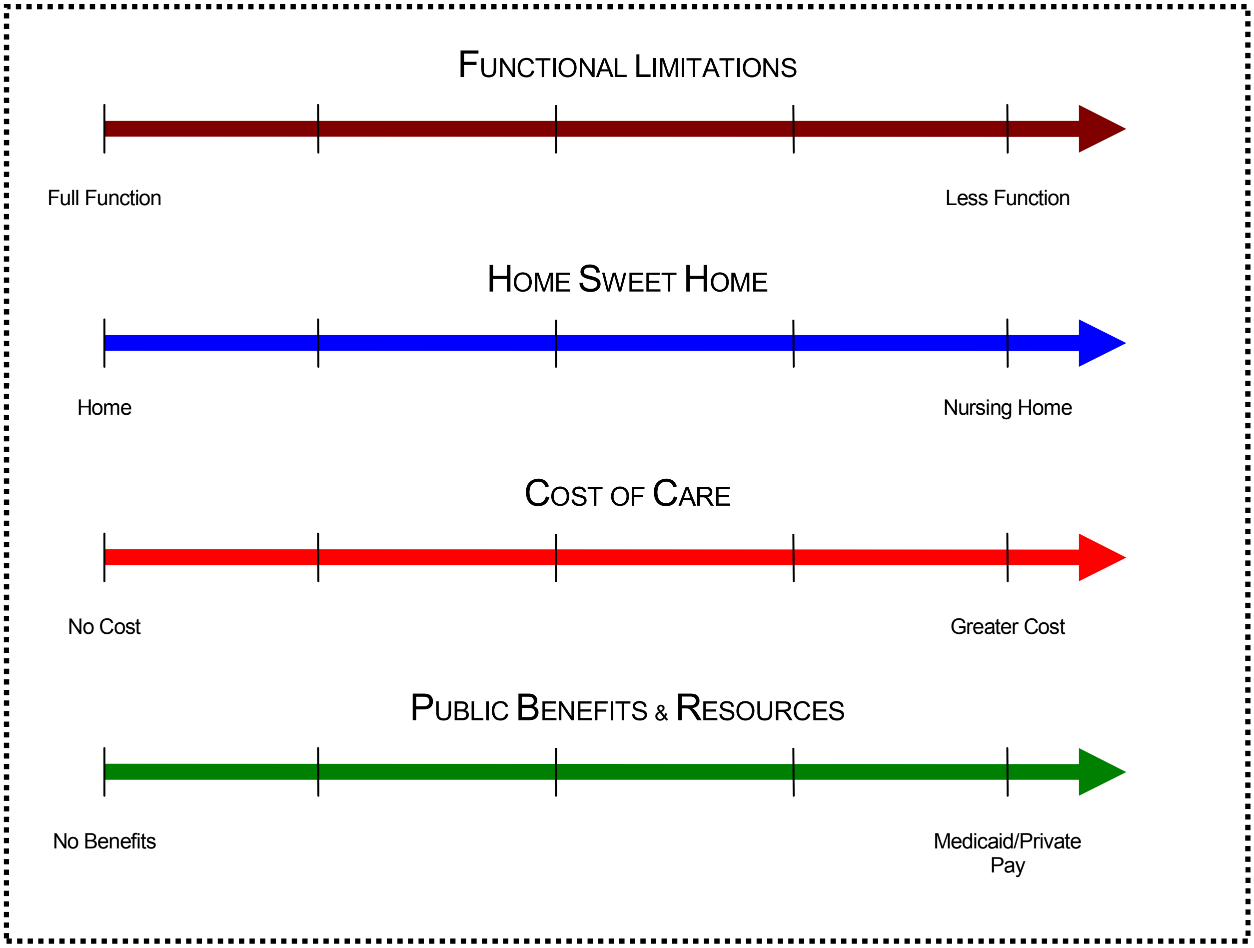
C. Who Needs to Plan? – The Great Divide

● : Healthy Older People (HOPs) = Legal + Financial

◊ : UnHealthy Older People (UnHOPs) = Personal + Financial + Legal

Fundamental: when an older person develops a chronic illness, the overwhelming need in his or her life is to *find, get, and pay for good care.*

D. The Elder Care Continuum



The Four Lines

1. Functional limitations
2. “Home Sweet Home”
3. Cost
4. Resources

Other factors that affect the client’s location on the Continuum and the rate of change along the Continuum:

Disease Trajectories

1. Cancer: high functioning, short period of evident decline leading to death.
2. Heart and lung failure: long-term limitations with intermittent serious episodes.
3. Dementia and frailty: prolonged dwindling.[34]

Co-morbidities

Co-morbidities affect disease trajectory, function, and rate of change on the Elder Care Continuum.

Risk factors threaten the good health, safety, well-being, and quality of life of the elder:

1. Falls
2. Medication mismanagement
3. Depression
4. Dehydration and malnutrition

Other risk factors: 5) alcohol, 6) tobacco, 7) obesity, and 8) driving

“Takacs Planning Complexity Curve”

Bell Curve:

- Planning complexity rises as the client’s functional limitation declines;
- Complexity falls as client’s functionality declines to a point where the client’s opportunities and options for care become increasingly circumscribed.

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[34] Joanne Lynn and David M. Adamson, *Living well at the end of life: Adapting health care to serious chronic illness in old age* (Rand Health, 2003). *See* Appendix: Disease Trajectories, *infra*.

E. The Caregiver's Perspective: Five Core Problematic Areas

Issues for Caregivers

- How do I get timely access to useful information and support, especially during a crisis?
- Can I rely on the care community to support me and my loved one?

What Decisions Do Caregivers Need to Make?

Five core problematic areas have been identified by researchers[35]:

Decision Areas	Problems from caregivers' perspective
1. Accessing help (how and when to access health and social services for the elder)	Refusal of help by patient; risk; confidentiality; physician denying problem
2. Considering residential care placement	Timing; finances; quality of care; previous promises; perception of clash with cultural values
3. Legal matters, including management of finances, power of attorney, continuing driving	Maintenance of autonomy; ethics; vulnerability; taking on new role
4. Deciding on non-dementia related care, including operations, end-of-life care, resuscitation	Timing; ethics; risk-benefit; quality of life; family-clinician agreement; culture
5. Making plans for person with dementia if caregiver was too ill to be a caregiver	Burdening family; quality of care

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[35] G. Livingston et al., *Making decisions for people with dementia who lack capacity: qualitative study of family carers in UK*, British Med. J. 2010:341:c4184 (Aug. 18, 2010).

F. The Elder-Centered Law Practice in New Health System Designs

The Elder-Centered Law Practice Represents the Patient

The Chronic Care Model: places the "informed activated patient" on one side and the prepared, proactive practice team on the other side. Planned, productive interactions lead to improved health outcomes.

Representing the patient, the Elder-Centered Law Practice seeks to develop an informed, activated patient.

The Elder-Centered Law Practice Seeks to Improve Its Clients' Chronic Illness Care

- Education
- Advice
- Support
- Ongoing care assessment, coordination, and monitoring
- Liaison and intercession with the health care community
- Intervention and advocacy
- Access to sources for payment of health care and long-term care

The Elder-Centered Law Practice Engages with the Health Care Community

How can an Elder-Centered Law Practice engage with primary care physicians (in the coming patient-centered medical homes) to assist clients-patients in improving their chronic illness care?

As an essential member of the Medical Neighborhood, the Elder-Centered Law Practice should have a presence early in an individual's care plan. Within the Medical Neighborhood itself, an Elder-Centered Law Practice is regarded as a specialty: a team of nurses, social workers, licensed therapists, public benefits specialists and attorneys, under one roof, experienced in helping individuals find, get and pay for quality care.

Here is an example of a common situation many older adults and their families face. Frank, 87, is a frail man who has been diagnosed with Alzheimer's disease. Living by himself at home, Frank is functionally dependent upon his overwhelmed son, Paul, to bring him his groceries, take him to the doctor, pay his bills, and get his medicine.

Where Frank lives – that is, whether or not he lives in a Medical Neighborhood – affects how successfully he and his son Paul will manage his care.

How would a traditional elder law practice view of Frank's situation differ from an elder-centered law practice approach? And, how does the elder-centered law practice approach meet the aims and goals of the Medical Neighborhood?

Under the traditional elder law approach, Frank currently has or will have a care financing and asset preservation problem. Typically, the elder law practitioner will be retained to put a plan in place to accelerate Frank's financial eligibility for Medicaid.

If Frank doesn't need immediate nursing home care, Frank will get necessary legal documents in place and counsel on repositioning assets to make them unavailable or inaccessible to the State Medicaid program. If he is a veteran, the elder law practitioner will determine whether Frank is entitled to monthly payments from the U.S. Department of Veterans Affairs (the "VA") to pay for his care. A plan will be developed that may require Frank to restructure his assets to qualify for a VA benefit.

This may be done by making Frank's assets legally unavailable to him. If those assets are not available to him, the State Medicaid program and the VA can't consider them available. The asset repositioning may result in a five-year Medicaid lookback period. Usually, the elder law practitioner will counsel Frank and Paul on the advantages and disadvantages of such restructuring.

How will Frank's needs for personal care be addressed? Or his values, or safety, or the risk that Paul will suffer caregiver burnout? Although the traditional elder law practitioner may offer Frank and Paul suggestions on accessing personal care needs, the elder law firm typically does not align its asset protection plan with the client's personal care needs.

An Elder-Centered Law Practice aims for whole-person care, assisting Frank and his son Paul with attaining their goals of addressing issues that impact health or that enhance or create barriers to care. What level of care does Frank need and what kind of care does Frank want? A plan will be developed and implemented to help Frank find, get and pay for the care that most closely aligns with his values and his needs today. Frank will get legal documents and asset restructuring advice; but care financing, albeit critical, is only one aspect of the representation.

The Elder-Centered Law Practice will employ a team of health professionals who will coordinate care and advocate for Frank and for Paul. The practice will have a working relationship with community resources including case managers, local social service agencies and residential and in-home care providers. The practice will offer Frank options. It is the aim of the Elder-Centered Law Practice to support older clients and their families in the day-to-day self-management of their chronic illnesses.

In the Health Affairs article quoted above, "Community Partners" are described as essential to improving health and health literacy. Health care providers are encouraged to establish relationships with nonmedical and literacy organizations to help patients manage their cultural and social vulnerabilities.

In this presentation, we have traced a line from the development in the late 1990s of the Chronic Care Model, to the Triple Aim (in 2008), to Patient Centered Medical Homes (in 2010, as a part of the Affordable Care Act), to the Medical Neighborhood (in 2012), to now: The Elder-Centered Law Practice as a necessary community partner and specialist that engages clients and families in the improvement of the experience of care, the health of the population, at a lower per capita cost.

The Elder-Centered Law Practice Holds Others Accountable

The Elder-Centered Law Practice

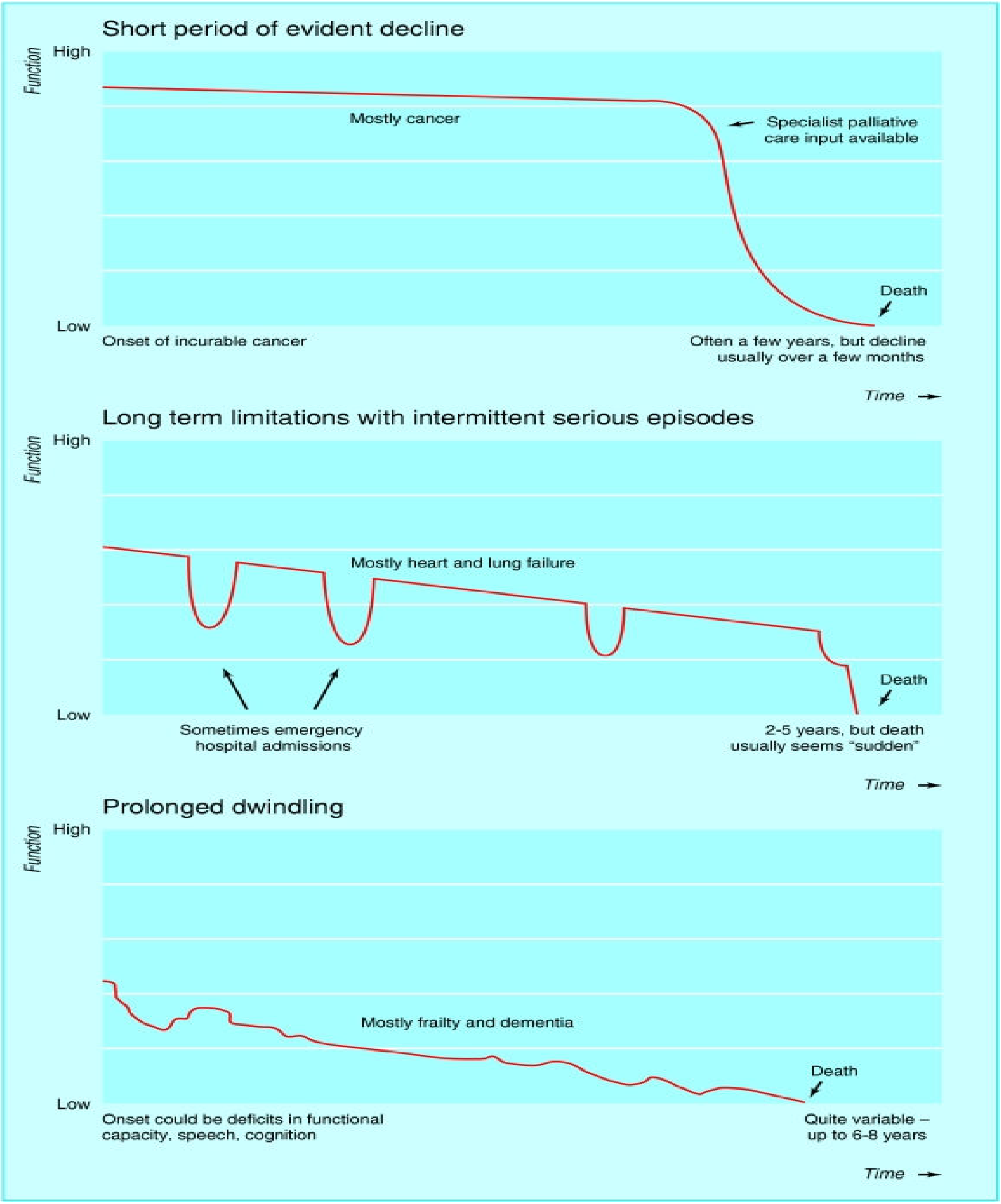
- Empowers its clients and families to become *informed, activated patients*
- Helps informed, activated clients *find, get and pay for good care*
- Holds others *accountable* to deliver good care

G. Questions the Elder Law Attorney Should Ask

Elder law attorneys tend to focus on legal documents and financing care. In planning for long-term services and supports, however, elder law attorneys should address these issues:

- What care (legal, financial, personal) is needed immediately?
- How will those needs for care change in the future?
- In addition to money or public benefits, what other resources are available?
- What health, social, and environmental problems affect the elder's chronic conditions?
- What are the needs of the elder's caregivers?
- Can this source of support for the elder be relied upon to continue?
- Is there a current or looming caregiver crisis?
- What health, social, and environmental problems contribute to the caregiver crisis?
- Preferences? How do these affect the planning?

Appendix: Disease Trajectories[36]



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[36] Reproduced from Scott A. Murray et al., *Illness trajectories and palliative care*, British Med. J. 2005:330(7498): 1007-1011 (Apr. 30, 2005).