Event ID: 833690
Webinar 1: An Introduction to Geriatrics-Competent Care

Operator: -- please press star, then 1 on your touchtone phone. You will hear a tone indicating you have been placed in the queue. A voice prompt on your phone line will indicate when your line has been opened. You may remove yourself from the queue at any time by pressing the star key, followed by the digit 2. If you're using a speaker phone, please pick up the handset before pressing the corresponding digits. Once again, please press star 1.

Moderator: Great. Thanks so much, Doug. Additionally, I wanted to note that on the Resources for Integrated Care website you can find the presentation for today and then next week the post-recording. These will be within the Geriatrics-Competent Care Webinar Series pages, which currently contains today's presentation and the biographies of our speakers. To get to the correct page use the Search field and type "introduction to geriatrics" from the home page. The first page result from the search will take you directly to the webinar resources.

At the end of today's presentation we're going to be asking you to complete a quick survey of the webinar, and we hope that you'll take time to complete this. We and our partners review all the answers to make sure future webinars are a greater success. And if you have any questions or additional comments, please feel free to contact RIC -- that stands for Resources for Integrated Care -- @lewin.com. That's, again, RIC@lewin.com.

Again, this is the first of two webinars that were developed as a collaboration between Community Catalyst, the American Geriatrics Society and The Lewin Group and supported through the Medicare-Medicaid Coordination Office in the Centers for Medicare and Medicaid services.

Now just a few words about the partners I just mentioned. So Community Catalyst, the organization I work for, is a national nonprofit health advocacy organization that works with consumer advocates in over 40 states to bring the consumer voice to decisions affecting their healthcare. The American Geriatric Society is a not-for-profit organization of over 6,000 health professionals devoted to improving the health, independence and quality of life for all older people. And The Lewin Group is a healthcare policy and research consulting organization that's worked extensively with governments, provider organizations and subject matter experts to support Medicare-, Medicaid-eligible beneficiaries and other high-risk populations.

Together with CMS we support providers in their efforts to deliver more integrated, coordinated care to beneficiaries. If you want to learn more about current efforts and resources we encourage you to visit ResourcesforIntegratedCare.com.

Just so you know that this webinar is 60 minutes of presentation followed by 15 minutes of question and answer.

At this time I'm going to turn to introducing our three speakers today.

Our first speaker is Dr. Gregg Warshaw. Although his full biography is available online, I'll give you a quick sense of where Dr. Warshaw is from and his areas of interest. Dr. Warshaw is an academic family medicine or family physician and geriatrician who serves as the director of the Geriatric Medicine Program at the University of Cincinnati College of Medicine. He's a professor in the Department of Family and Community Medicine and the Martha Betty Semmons Professor of Geriatric Medicine.

Dr. Warshaw's academic interests include geriatric medicine education, preventive health care for the elderly and the impact of hospitalization on older patients. Dr. Warshaw is a 2013-2014 Atlantic Philanthropies Health and Aging Policy Fellow and an American Political Science Association Congressional Fellow. Through these programs, he's consulting with the Division of Chronic and Post-Acute Care at CMS. He's also assisting Community Catalyst's Voices for Better Health project and working with Ohio advocates to bring expertise in geriatrics into the dual-eligible demonstration projects.

Our second speaker is Dr. Kyle Allen. Dr. Allen is the Vice President for Clinical Integration and Medical Director of Geriatric Medicine and Lifelong Health at Riverside Health System in Newport News, Virginia. He's the former chief of the Division of Geriatric Medicine and medical director of the Institute for Senior's and Post-Acute Care at Summa Health System, in Akron, Ohio.

In his current role at Riverside Health System he works to develop a health systems approach to improving care for older adults those with serious and advanced illness. Dr. Allen is an alumnus of the Practice Change Fellows Program, which is a national leadership development program for geriatric leaders and clinicians sponsored by the Atlantic Philanthropies and the John A. Hartford Foundation. He current serves as a Senior Advisor for phase two of that program.

And our third speaker today is June Simmons. Ms. Simmons is the Founder, President and CEO of Partners in Care. She has pioneered evidence-based research which has led to innovative interventions for the management of chronic conditions, and coordinated care to improve health outcomes. Throughout her distinguished career Ms. Simmons has been instrumental in envisioning, creating, funding and operating forward-looking health and social service programs which meet the mutual needs of patient populations, providers and health care delivery networks.

And, again, the full biographies and contact information for all three of our speakers is available on the Resources for Integrated Care website.

Now, before I hand the presentation over to our first speaker, I'd like to take a few quick polls to see who we have on today's call. Here's the first one. The first question is which of the following best describes your professional area? There are six choices, and you can choose as many as apply. Just click on however many you'd like and hit Submit Your Answer. We'll give you a few seconds to do that. Okay, I see a number of people are responding. We'll give you two more seconds. Okay.

Okay, here's the results. It looks like we have a majority of our audience from medicine, nursing or physician assistants, with a tie between people from the healthcare administration field as well as from the advocacy field, with a very close third in social work. So we appreciate that.

Our next quick poll also is aimed at understanding who we have on today's call. If you could click on, again, as many as correspond to your role. What's your primary role in your current system?

Okay, looks like we've got a lot of answers in. The majority are clinicians. We have a great representation from consumer advocates as well as administrators and educators, and some researchers, as well.

And one final poll. We want to understand what settings you work in. And, again, you can choose as many as apply.

Okay, it looks like we've got almost all of our respondents in. Okay, and here are our results for today. The majority are from other, but we have a lot from managed care organizations, and looks like consumer organizations and long-term care facilities are sort of close seconds. But thank you so much for letting us know where you're from.

We're going to move on to the presentation, and I'd now like to hand things over to Dr. Gregg Warshaw to get us started. Dr. Warshaw?

Gregg Warshaw: Thank you, Renee. We'll start off by looking at some aspects of older adult care which are really unique to this population.

Next slide. One of the principles of working with older adults is the diversity among this population. We all know this from our families and from working with older people, but the older adult population in the United States is very diverse in terms of their physiology, their functional ability, their cultural backgrounds, which means that more than any other age group care for older adults must be individualized. Frequently evidence-based, protocol-based care may not always apply to an individual in the older age group, and this is a challenge for clinicians, and it's important to take each patient as a special case.

Next slide. In humans, the normal aging process is certainly not a disease. It's just part of our species' physiology. And it occurs at different rates among individuals and even within individuals. Some people may have more rapid aging of one body system, whether their heart or their lungs, than another. Generally, though, normal aging in humans should not cause symptoms that would lead to functional decline or disability. So aging in itself is a relatively benign process in humans, and our expected life span of about 100 years is pretty constant.

Next slide. When we look at an individual and understand the decline in normal function, there are usually at least four processes going on. As I mentioned, physiological aging is a relatively benign process and should not interfere with day-to-day functioning. There is also the risk, as we age, to develop diseases, and, as many of us know, multiple chronic conditions do represent a large portion of the experience of older people in today's world. Diseases do affect function, but

they don't have to be -- they don't have to lead to loss of independence if they're managed well. There's also clearly an association with function and physical activity, which we'll talk more about.

And then finally, as we age, we do accumulate a lot of changes that are associated with some of the habits we've had during our life. So those of us who have smoked more tobacco or had more alcohol to drink or maybe were not as careful about some of our use of medications can see a decline in function that's related to some of our habits.

Next slide. Let's look at a case at the moment, and we'll ask you to pick an answer for this case. This is an 83-year-old woman who comes to an outpatient office setting for an examination. She has recently returned to her home after a motor vehicle accident that resulted in injuries and a hospital stay complicated by pneumonia and a nursing home stay. So she's been to the hospital and to a nursing home before coming back home and seeing you.

She is greatly changed since her last office visit before the accident. She has lost a lot of weight. She moves slowly and is unable to rise from her chair without using her arms. She previously was an avid golfer and swimmer. She asks what she can do to improve her function now that her injuries have healed.

Next slide. You get to pick one of these answers.

Moderator: Looks like we're still getting our votes in. We'll give it maybe 10 more seconds for people to submit an answer. And here are your results, Dr. Warshaw.

Gregg Warshaw: Thanks. The case described, a situation which is pretty common in older adults, where they've been pretty physically fit and active like this woman but then had some medical or accident problem which has caused them to have to go through the healthcare system and receive treatment. And when they've come out of that process they are not functioning at the same level they were before they became ill. This is essentially a rehabilitation emergency. We need to act aggressively to help this woman get back to her prior state of function.

I would think that the best answer from my perspective in this question would be the recommendation for more exercise and rehabilitation. However, comprehensive geriatric assessment and a home visit to evaluate the function in the home might lead to that recommendation. So those are good choices that one would hope would lead to the recommendation for exercise. I was glad to see that people recognize that there's very little evidence for protein supplementation in a case like this, and there may actually be some adverse effects from anabolic steroids. So I think everybody was really on target on that question.

Next slide. Those of you that work with older patients realize that function is the critical outcome. When I talk to my patients about what I can do for them they mostly want to know what I have to offer them that'll allow them to stay independent. Of course I have a problem list and diagnoses that I pay attention to and we try to work on treatments that will improve function. Treatments that don't improve function or cause decline in function are less advantageous to older adults.

Next slide. Part of our way of approaching the complexity of aging and health and social circumstances is through the principles of geriatric assessment, with the goal of trying to promote wellness and independence and improving quality of life. And the focus is on function. It includes a careful evaluation of physical, cognitive, psychological and social domains, and is usually an interprofessional process that involves input from a variety of health professions. The next webinar in this series will focus on geriatric assessment.

Next slide. In order to personalize the care for an older adult, the care planning process is an essential part of healthcare delivery. Working with the older adult and their family, the goal is always to try to understand the patient's expectations and goals in the healthcare system and to make sure that we provide the right amount of care, not too much, not too little. There are examples I'm sure many of you have seen where older adults received much more treatment than you thought was appropriate or seemed reasonable and caused a lot of adverse events that created problems for the older person, and then others may have seen a person go to a physician who said, "Well, you're 80 and we're really -- there's nothing we can do anymore." That would be an example of just not getting enough care if it was not the right approach.

And then, of course, we're always looking to provide care in the right location, and that's usually the least intensive. Older people are at risk in the healthcare system, and as much treatment as we can give in their own home or in the outpatient setting the better. The hospital should always be the last choice.

Next slide. Another really useful principle in working with older adults is that in cases where there's time to think about the approach to a problem -- I think we just skipped ahead one too many. Can we go back one? Thanks. I think now we have to go -- oh, I think we're okay. All right. There we go. Perfect. When there's time to think about a problem it's usually helpful not to act too hastily with older adults. That gives you time to work out a plan of care, to think about what the best location and treatments are, and to make sure that whatever plan is in place meets the patient's goals and puts them at little risk of problems from contact with the healthcare system. I call this slow medicine, but it's really useful in older adults.

Next slide. We've already made reference to the fact that in working with older adults it's really essential to participate in interprofessional team care. And that's because there's just a variety of expertise that's required to provide the best care to older people and no one discipline really has all the information necessary to provide that care.

As an example, when I speak to physicians about working with older adults I make it quite clear to them that I don't expect them to become social workers, but it's pretty important that they know a social worker and have their phone number on their desk. Otherwise they're just not going to be effective with their older population.

Next slide. Let's say a few words about approach to prevention in older people.

Next slide. There are standard recommendations for prevention, either immunizations or screening tests in older adults, that are usually derived from information that was gathered on

younger or middle-aged adults. As we've talked about before, every older person is an individual with their own goals and expectations and past history, and preventive medicine needs to be very individualized in older people. Most people will benefit from some small number of immunizations and screening tests, but maybe not all of them will be necessary, particularly as people get into their 80s and 90s.

Finally, there's opportunities to do some other preventive work with older people, such as identifying their risk for falling or their risk for having problems with cognition. And we'll be talking more about falling in just a minute.

Next slide. I made reference to the difficulty older people may have within the healthcare system, either from experiences in institutions, from diagnostic tests or from the use of medications. We call this iatrogenic illness, and it's a particular problem for older adults, because they may have very limited physiologic reserve, may be a little frail, and they're doing fine as long as we don't tip them over the edge. And sometimes some of the treatments and tests we come up with might trip them over the edge, may lead to problems with confusion, falling or other geriatric syndromes.

So the risk and benefit of diagnostic tests and treatments is much more narrow in older people. You can't get away with as much as you could with a younger adult. And so we'll try to be extremely careful in our use of these types of tests and treatments and medications.

Next slide. Back to our case, we emphasized the importance of exercise in order helping the woman recover from her automobile accident. For every older adult, exercise probably is the only evidence-based fountain of youth. It really is a critical feature in allowing older people to stay independent. It promotes mobility and decreases the incidence of some heart disease and bone disease and thinning of the bones.

There's a variety of different types of exercise approaches. All of them are important, whether they have to do with flexibility or endurance or strength or balance. And engaging in exercise can be a very self-actuating event for older people. If it's done in group settings it can be a social support. And it's a wonderful thing to recommend for older adults.

Next slide. Many of you may be aware that Medicare has recently enacted a billable service called an Annual Wellness Exam. This allows an older adult to come to their primary care physician's office and not receive your typical history and physical but have the office staff and the doctor review their basic function, the medications they're taking with the other doctors they're seeing, their advanced directives, their goals of care. It's a sense, a time to really do a comprehensive mini-assessment on that person on an annual basis. And this is not something that was reimbursable a few years ago, but primary care practice now can receive payment for this service, and it's a wonderful opportunity to do a better job of documenting the wishes of our patients.

Next slide. I'm sorry, I lost my screen. I'll be right back. Now we're going to talk for a minute about care transitions, and could we have the next slide?

Care transitions refers to the movement of patients within the healthcare system. It can be between providers, when a person is referred from their primary care physician to their specialist, or it can be between settings, where somebody is in the hospital and maybe moves to the rehabilitation part of the hospital or out to a community nursing home or into home health in their own home.

We understand care transitions are a period of stress. Patients are in the system because they're ill. Families find the system confusing. It's hard to advocate for their loved ones. And there's an opportunity for professionals not to communicate well and errors to occur. This once again is more of a risk for older adults because of their limited physiological reserve.

Next slide. This is just a visual representation of some of the care transitions that I mentioned. And, as many of you know, this is an area of significant interest right now, and we'll be talking a little bit more about this later in the hour.

Next slide. I'm now going to turn the presentation over to Dr. Kyle Allen, who will begin speaking about medication use in older adults.

Kyle Allen: Thank you, Gregg, and welcome, everyone, to the webinar today. I'm going to build off of some of the principles and concepts that Dr. Warshaw has mentioned as it relates to one of the more common safety issues and one of those iatrogenic problems that Dr. Warshaw referred to, and that's around safe medication use in older adults.

Next slide. So, as I mentioned, it's a real -- a lot of safety challenges that happen related to older adults and the prescription of medications. Many new drug treatments continue to be developed trying to manage multiple chronic illnesses, and because of that juxtaposition of multiple chronic illnesses and medications is kind of where the risk comes in, as well as older adults being predisposed to adverse drug events because of some of the physiologies -- the physiology of aging that Dr. Warshaw referred to.

Adverse drug reactions are common. We also often refer to as there's drug-drug interactions as well as drug-disease interactions that you have to be aware of, and this largely is related to that physiologic reserve, that place where older adults are vulnerable.

And it's also difficult for older adults to manage multiple medications. I don't know if any of you have tried to be adherent with just one medication. I know I have difficulty. So when you're five or six as well as complex medications such as nebulizers or inhalers become difficult, and so problems with vision, arthritis, understanding the directions for medications become an issue.

Next slide, please. One of the things that I always used to kind of argue with the drug reps when I was in private practice is I said, "Well, tell me what the studies were on older adults." And they would always have kind of a blank face, and the reason being is that older adults aren't often included in some of the drug studies, and so the evidence is not there of what some of the adverse events are. I think the pharmaceutical world has gotten better of trying to be inclusive of older adults, but just like this morning I saw a commercial about a new drug that had been

released and the concerns about it. So you've got to take kind of this precaution that new drugs may or may not be that safe in older adults.

And when they're taking multiple drugs, as I mentioned, a lot of safety and efficacy of individual medications are counterbalanced with each other, such like medications for memory impairment but you're also trying to treat urinary incontinence, and the side effect of the urinary incontinence medications affects the memory drug. So you really have to be very, very mindful. And, again, it affects the outcomes of pharmacotherapy.

Next slide, please. So you really, as a clinician and a prescriber of medications, you really need to be very, very attentive to this when you're taking care of older adults, and that those axioms that Dr. Warshaw spoke about about slow medication and taking your time, you really, really need to think through the risks and the benefits of medications.

And here it talks about one clinician taking responsibility for medications. And that's a little Pollyannaish today in the healthcare system, because most people have multiple doctors. And so one of the things I like to emphasize is really making sure that the patient is engaged in their own medications and understanding as well as their caregiver. And I think that's probably the best safety net that we have, as well as being a little bit broader in the use of the team of using a pharmacist. And I was a little bit chagrined that there weren't very many pharmacists attending today's webinar, because I think pharmacists can play a major role in this.

I think the regular review of all medications and making sure that there's a review of what am I treating with this medication versus what problem not only annually, but Dr. Warshaw mentioned about care transitions. And I think that is probably one of the greatest vulnerability and safety issues around medications is at the time of care transition. So special attention is really needed in the reconciliation of medications and getting that clear, particularly from home to hospital, hospital to post-acute skilled or home health and then back home gain. And that's where we actually see a lot of dangers and problems with issues of omission, commission, confusion around medication, so paying very, very close attention about medication review at the time of transition and annually, and be very, very methodical about when you're going through the medication list about what it's for, is it still needed, what's it treating, what are the drug/drug interactions, things like that.

Next slide, please. So some general approaches, which I've kind of talked about some of them already, but one of the first things is nonpharmacological approaches. And one of the things we used to teach in fellowship and teach the residents is -- and it's kind of a quip and a joke, but it makes people remember -- is that all drugs are poisons, and some have a few beneficial side effects. And so if you kind of take that attitude particularly in older adult prescribing you're going to be a safer prescriber to those folks.

That axiom of start low, go slow. Evaluate thoroughly as needed. Caution with any new medication. Understand really was the drug studied in older adults. What did the literature show? What did the research trial show?

As well as one of the considerations I used to have is I used to wait. People would come into the office and they'd say, "Well, I want to try this new drug." I said, "Well, let's wait for a while." And then what happens, you start to hear these different reports of falls and some of the sedative hypnotics causing amnesia and hip fracture. So I really think being that conservative and that cautious is a way to provide safer prescribing in older adults. And always keep inside the side effects in aging physiology.

Next slide. So before prescribing a new drug, as I went through, you go through this thought process. Is it necessary? What am I really trying to treat? What's the risk versus benefit ratio? Is it going to actually counteract another drug that's in the treatment regimen? Could I simplify the drug regimen at all by using one drug to treat two conditions, and maybe not do it optimally but do it satisfactorily? Maybe precision here is not the end game.

And making sure that your patients and caregivers are educated. I think that's extremely important. I know June will touch on that and some of the evidence and ways to do that.

Next slide. So now I'd like to talk a little bit about understanding geriatric syndromes, because these are probably the challenge, I think, to most people taking care of older adults. I think this is where we need more education and knowledge and understanding. This is where geriatric providers have really kind of earned their keep, if you will, of being able how to manage syndromes, so to speak.

Next slide. And the reason that we kind of use this term "geriatric syndrome" is because there's a lot of kind of interacting forces that happen to older adults between the physiology of aging, the things that Dr. Warshaw talked about, the natural part of aging and then the disease processes that are more prevalent and that can occur as we get older kind of set us up for these geriatric syndromes.

And I would say that they not are typically, they usually always are multifactorial, geriatric syndromes are. There's usually multiple things going on at one time to present what is the syndrome, so to speak. You don't usually see these in younger people, and more common in older adults because of the makeup of older adults, as we have discussed.

Next slide. So most older adults have three or more chronic conditions or illnesses, and these multiple illnesses are associated with increased rates of death, disability, adverse effects, towards institutionalization and use of healthcare resources, and really impacts their quality of life, particularly around impacting function, as Dr. Warshaw talked about. It's really the combination and accumulation of these things that impact function, which really is where that starts to change the quality of life and ability for an older adult.

However, older adults are very heterogeneous, too, in their geriatric syndromes as far as progression, degree of severity, personal priorities and risk of adverse events. So the reason for comprehensive geriatric assessment, as you'll learn in the next webinar, or will be discussed in the next webinar, that's really what gets -- using geriatric assessment and that tool is really very effective at looking at geriatric syndromes.

Next slide. The most significant geriatric syndromes are these lists that you see here. We're going to only talk about one today. Each one of these are probably a lecture, an hour lecture or more in and of themselves. But we're going to pick the most common one today and talk about falls.

Next slide. Falls is one of the most common geriatric syndromes. That's why we wanted to pick it so we kind of use it as a kind of a prototype of understanding the concept of geriatric syndromes. It's about 60 percent of older adults fall or have a history of falls. And the complications of those falls is a leading cause of death and injury in those over the age of 65.

And despite common belief, most falls are not associated with loss of consciousness or syncope, either in the literature or as a cause, but it can be an associated factor, this kind of decreased blood flow to the head, the brain, which is really what causes syncope. And falls, like more geriatric syndromes, have multiple etiologies going on.

A fall in an older adult should make one sit up, pay attention, and say this is a sentinel event. I need to find out what's further kind of under the water, if you think of an iceberg. It's like the tip of the iceberg, the fall itself. There's lots of other things going on that you need to try to uncover of why did that person fall.

Next slide. So, again, you want to -- for falls you want to go through this comprehensive assessment, asking on review of systems have you fallen in the past year. That's why that's a part of the annual wellness -- Medicare Annual Wellness Exam that Dr. Warshaw spoke about. A single fall, like I said, should be treated as a sentinel event. Recurrent falls, or balance, is really trying to find a medical -- taking a really good medical history, a physical examination, looking at vision, looking even at hearing, looking at feet, looking for bunions, looking for what kind of shoe wear are they having, as well as actually doing some environmental aspects at home and safe-proofing the home as a safety assessment that needs to take place at home.

Next slide, please. These are kind of the things that we look for in that assessment, as I mentioned: environmental hazards; and postural hypotension we often refer to as orthostatic hypotension -- that's a drop in blood pressure when you stand up or from a seated to standing position or from a lying to sitting position, and it can be a factor related in somebody feeling wobbly and dizzy and having a fall; making sure visual acuity is checked, and understanding gait and balance disorders, which those are also more prevalent in older adults; making sure we assess muscle strength in the lower extremities, and foot and ankle; all things that really need to be assessed in a comprehensive way when somebody falls and has an injury.

Next slide. And how we try to approach falls treatment again is in a multidisciplinary way. I think one of the guidelines is that if somebody falls and injures themselves they really should be seen by physical therapy and/or occupational therapy but for sure physical therapy, to really look for balance and gait disorders as well as this thorough examination.

There also needs to be a home assessment, which sometimes is very difficult in the healthcare system, because we don't have eyes in the home. But you can give handouts for people to do it. June'll talk a little more about that. But really where most falls occur is around steps, poor lighting, rugs, cords and things like that. And sometimes it's hard to get people to change that. I

know it's difficult with my mother, who just recently had a fall. And I keep telling her about getting rid of the throw rugs, and, no, those are really important to her and she's going to leave them there. And then I try to tell her about what the consequences would be, but she doesn't listen to me.

And so next slide, please. That team approach is really important. I'm really going to now turn it over to June, who literally is going to bring us home, where most healthcare is delivered, and she's going to tell us more about this team approach and the need for community-based integration.

June Simmons: Thank you so much, Kyle. It is true that there are expanding -- there is an expanding focus across medicine in interdisciplinary teams, and the role of social work has been emerging. So with geriatrics, where traditionally geriatricians have been very familiar with the value of the social worker and getting at some of the whole person and how people live and how it affects their health, that is now expanding, so that geriatrics is better served through stronger social work and similar extensions.

But also across medicine, we'll discuss, there's a targeting especially of older patients of people with complex conditions, and we see the eyes and ears in the home that Kyle was referencing as one of the new settings, a great deal of work in the post-acute area to facilitate coaching with the Coleman model and others to stabilize people as they change from an institutional setting to the home, so a lot of expansion under the Affordable Care Act that is moving some existing reimbursement over to support these kinds of interventions.

Next slide, please. So we see, then, that the expanding focus draws on some community resources that have been available for a long time, and we're focusing on trying to build now community-based services as a fourth leg of the accountable care organization, as a new specialty in the interdisciplinary team with looking at modifiable risk factors at home as we try to look at population health and move to best health results.

There are, of course, many existing resources available, but they have to scale up. They have been around for decades but have not been built to the volume and ready accessibility that we need to achieve now as we have this aging silver tsunami, if you will. And so I think that one of the key roles is for social workers to be the eyes and ears and identify these modifiable risk factors, especially at times of transition, to identify risks -- those rugs in Kyle's moms home -- if she won't take them up, what do we do about it, and how else can we make it safe -- to identify other unmet needs and facilitate access to existing and growing social services benefits like home care, personal care, food, transportation, so that people can get right care, right place, right time, less use of the ER and the hospital by staying more safe and stable at home.

And in addition prevention is a major focus, as we've been hearing, and helping to deploy some of the now well-established evidence-based self-management programs that help individuals manage chronic pain, manage diabetes, arthritis, other chronic conditions. Because one of the best ways to achieve better health outcomes is to help people change the way they manage themselves.

Next slide, please. So, when we deploy a health coach or a community health worker or a social worker to the home to be eyes and ears, what they do conduct is a psychosocial and environmental assessment. It may be a very brief intervention to just get data into the health team, or it may be part of the long-term supports and services resources that follow people over time to coordinate arranging and purchasing augmenting services to help them remain independent and avoid institutional living.

So the functional assessment is critical, of course, and seeing that in the home is basic to getting at the truth, if you will. What people report they can do may be different than having them actually get up out of the chair they really sit in. We had a woman who was falling frequently recently, and the assessment revealed she was falling in the kitchen, and the contributing cause was she had chairs that had wheels on them, and no one knew that. And so sometimes there's a function and the ability to be stable and sometimes it's environmental, sometimes it's a combination that leads to fall risk, the hazards that Kyle mentioned.

But one of the documented greatest contributors to fall risk is medications. It seems that medications contribute greatly not only to falls but then to emergency room use and hospitalization. And so looking at lighting and tripping hazards, but also medications and other issues is a powerful set of information needed to have a fully integrated care plan.

Screening for depression and early cognitive impairment, of course. Looking at the environment, home safety, cleanliness. We discover hoarding, which you can't always tell in an office visit, deferred maintenance for safe and navigable stairs and so on, the identification of barriers to compliance with treatment plan, and then observable evidence that may not be reported, such as alcohol bottles in the trash or a kitchen that's out of control. And so then identifying also the social supports, are they supportive or dangerous? Lots and lots of emotional, physical and financial abuse that needs to be identified. But also caregivers get worn out, and they may need respite or help with gaining in skills and knowledge and how to manage either dementia or other kinds of conditions that require ongoing and intensive caregiver support.

Next slide, please. So, this slide's a little small to read. I don't see it on the screen. What I was pointing to was a graphic that looks at the Medicaid waiver that you will find in most states -- there it is -- and a very thorough assessment such as I just described would lead to a problem list and then a care plan for the long-term supports and services needed to help people remain safe, stable and living in their independent home environment as long as possible and as long as it's not too isolating.

And so the Medicaid waivers that are in most states do then first try to refer services. This just gives you an idea of the range of services that may be called upon to help keep someone safe. And then they also can purchase services, as you see on the left, where they may buy things with the Medicaid dollars that are not medical, not driven by medical claim, but are driven by these other factors but become an approved waived version of Medicaid.

Under health reform and the duals demonstration in particular we see then this model, which is small in scale, scaling up, and we also see private health plans beginning to test using this model but using it more briefly. The Medicaid waiver is, if you'll pardon the expression, kind of a "till

death do we part" program that can last as long as needed. Now we begin to target much briefer versions of this and will be testing to see what dose of in-home coordinated care is needed to really make this work. There's some research that shows just targeting tipping points or the points of change is really -- a series of episodic brief interventions may be better.

Next slide, please. So we're seeing across the country a major focus on building community partners with social services and medicine, working with health plans, physician groups, hospitals, to really look from a population health management perspective at improving health for adults, especially those with chronic conditions and multiple chronic conditions, bringing in these assessments, care plans, and also the self-management evidence-based programs. These are designed because we know that these are drivers, social determinants of health that will really, when deployed, when identified and addressed enhance the impact of medical care and thereby improve health outcomes.

Next slide, please. We especially see this under the duals, where the shift for the risk for paying for the nursing home moves from the government to health plans and physician groups and then the need for these long-term supports and services becomes much more widespread and very motivating. It keeps people where they'd like to be at a much lower cost and a higher quality of life.

So we see, then, the healthcare and social services working together as designed to achieve better health and continued independence by addressing those social determinants of health. Just to summarize, the functional status, how people live and choose their health behaviors; looking at degrees of isolation, family structures, caregiver needs; assessing both the in-home and outside-the-home neighborhood safety factors; and looking at the questions of economic insecurity and the need to supplement services that people can't afford but may be entitled to.

So community organizations have a unique capability to be going into the home without an obligation to provide medical care. So they have skills in getting into the home. The organizations typically have cultural and linguistic competence. They know resources in the neighborhood. But they also are really focused only on these things. And they also have lower cost and more readily available staff and an infrastructure for this kind of work, so -- and then the Administration on Community Living has been building a network, as well, of evidence-based programs for the last eight years to make resources available that medicine can identify the need and then target and connect the people in need with these kinds of programs.

Next slide, please. So we see then expanding supports for aging well, expanding the deployment of social workers, health coaches, community health workers, promotoras, peer leaders, so augmenting medicine with nonmedical resources that identify the challenges and threats to aging well, especially for complex patients. And we see the more recent addition of the programs that are established for patient activation to really address lifestyle change, and especially to manage chronic conditions and risks of falls and to help people know how to navigate the system and to support caregiver skills. So proactive kind of more holistic care we see emerging, at least here in California, and I think across the country we see many groups working to build these new not just partnerships but business infrastructures to support them.

Next slide, please. So we all know there's not enough resource for everything we need to keep people safe and keep their, well, their health ideal, so targeting for the population health management to decide where would you invest these kinds of resources that have not been so widely deployed in the past. Then we look, of course, and we can see in this pyramid that the vast population of patients does well and is doing fine and just needs medical support and prevention and monitoring.

But as chronic conditions begin to move in, and we all know that that eats the bulk of the medical dollar in America, then we begin to see that there is so much that can be done in lifestyle change and in risk management, that these are really becoming of interest. They're kind of the next generation. If we looked at home and community-based services, this would be community 2.0, because they exist but they really need to be scaled up.

Up above that, though, where we see people coming out of the hospital and they're at risk of readmission by certain clear and measurable criteria, they're coming out of the nursing home to return home, those junctures, or people who just have too many meds, or you can't get the result you want, then these are people for whom the post-acute, the brief and long-term supports and services, that evaluation would make sense. So they're the hot spotters, if you will, where you want to really get them into right care, right place, right time.

Next slide, please. So that targeting for the deployment of these kinds of home and community-based services, social services, really focus on concentration of risk, so function, mental capacity, degree of frailty and disabling conditions, or brief serious illnesses or progressive serious illnesses or a symptom that looks like inappropriate emergency room and hospital use because they're not able to access care when they need it.

Next slide, please. And medications is one of those signs that we look to to see how we can intervene and coordinate care better, as Kyle noted. So home and community-based services, the research is now emerging that shows that they do in fact have an evidence base that they are of high value. We know for decades that they can improve the quality of life and support patient choice, enhance health and are very cost-effective, therefore are a friendlier resource in this new time.

Next slide, please. So we see, then, in the next slide, a summary of kind of the service line, if you will. So we start with earlier interventions with the evidence base, and we'll look at what some of those are, for people who are independent but have a chronic condition. Then we move to the addition, and this is really an addition, of short-term in-home services. Especially we see it around the effort to reduce post-acute 30-day ER and hospital use, but also in primary care, that the 2.0 of that is going to be screening to identify people at risk in primary or geriatric evaluation and bring more short-term stabilizing in-home support.

And then the long-term services and support just kind of, I don't know, I think it's new language. It's coming out through the duals for the very frail and disabled to really invest a lot more readily in the service coordination needed to make sure people can have a safe and decent life at home.

Moving to the next slide, then, we'll look through these arenas. So just to point out Administration on Community Living and CDC and other portions of the government are supporting these kinds of programs where they're scaling up and have been for some time. For instance, the Stanford Chronic Disease Self-Management program is now in 47 states, 20 nations. These are becoming kind of recognized. They have strong random controlled trial information under them.

Medication management, HomeMeds is a nonmedical -- these are all peer led and not medically led. They're medically inspired and identified and referred, but, for instance, med management, the HomeMeds program is an example of an evidence-based program that can be conducted by a social worker or a health coach, very unfamiliar sources of meds review but available to go to the home.

But most of these are workshops in the community, available now. You can find them. And go to your state department of aging for those.

Next slide, please. So nearing the wrap-up here, just quickly to emphasize again, because it's the number one driver of what goes wrong, exercise is the number one cure and meds management is a close second to really managing population health. And this can easily be done, of course, a home visit by a nurse. Home health does this all the time. They gather this data. Anybody who goes to the home -- Meals on Wheels, a social worker for the Medicaid waiver, the post-acute transitions workers -- they all collect comprehensive meds information. They assess for possible adverse efforts, especially if they're using an evidence-based program that can – some now work backwards, looking at an adverse medication reaction kind of symptom and tracing it to see if it's connected to a medication that might cause that.

Pharmacist review is critical so physicians don't get a lot of false positives, but the pharmacist doesn't need to be the one to drive to the home. Who do you want to pay to be in the traffic? And if there's not a medical care that's needed in the home, then a nonmedical resource can provide this.

And then we see then a number of emerging models evolving here, and all of the post-acute care transitions programs focus on meds. So we refer you to the literature for that, but there are some excellent evidence-based programs out there like HomeMeds and many others.

So, next slide, please. So, this is the final slide. The post-acute home coaching is frequently done by now community-based organizations. CMS selected because of Section 3026 of the Affordable Care Act to test a new Medicare benefit with Medicare fee-for-service patients that follows -- that identifies patients who are actually at risk of readmission by certain set criteria and then follows them home and sees them immediately post-discharge, and then coaches them how to access healthcare appropriately, looks at their meds, makes sure they have follow-up care in place -- very simple interventions.

And locally here we've seen one that was done under that program that more than -- for the high-risk patients who had a 30 percent risk of readmission. With this program the program achieved a just below 12 percent readmit rate, so dramatic impact with a very simple intervention. We

have a scientific term for it. We call it the "duh" intervention, because it's obviously finding just basic gaps. And same thing, reduce ER use dramatically, and identify huge medications issues that after pharmacist review 63 percent had really major, important meds issues to be reported. Falls risk, 77 percent of the people.

So on the next slide we can see then that you've listened kindly to a big overview, and I think then our moderator is going to take over and move us to questions and answers.

Moderator: Great. Thank you so much, June, and thank you again Drs. Warshaw and Allen for your wonderful presentations.

We do have time for questions, and in the time that we do have remaining we're going to turn our attention to questions that have been coming in via the Q&A function online. If you have a question and you haven't asked it yet, please use the AT&T operator or type the question into the Q&A field on your screen. Doug, would you mind reminding our participants how to ask a question over the phone line?

Operator: Yes, thank you. As a reminder, if you wish to ask a question, please press star, then 1 on your touchtone phone. You will hear a tone indicating that you have been placed in the queue. You may remove yourself from the queue at any time by pressing the star key followed by the digit 2. If you're using a speaker phone, please pick up the handset before pressing the corresponding digits.

Moderator: Great. Thank you so much, Doug.

So I'm going to turn to some of the questions that came in over the Q&A. We'll start with a couple of clarification questions. This one can be for anyone. I think, perhaps, June, this one can come to you since you were the person who last spoke of it. Somebody wanted a clarification of what a dual is.

June Simmons: Oh, surely, I'm sorry. A dual is a dually eligible individual who has both Medicaid and Medicare. There are 14 states that have been selected to test integrating these two payment streams on the assumption that they can be much more complementary and when coordinated will have a tremendously valuable impact on bringing the right resources to people to help manage their health at a higher level and to avoid the inappropriate use of institutional care, especially nursing homes, but also ERs and hospitals.

Moderator: Thank you so much, June. Dr. Warshaw, coming back to you, also a question of clarification. Someone mentioned that you said something about 100 years being standard, if they understood it correctly. Could you clarify that?

Gregg Warshaw: Yes, thanks. That's a great question. I may not have spoken entirely clearly. There's two terms that I find I get confused with this and other people get confused with. One is life expectancy and the other is life span. And in the use of the 100 years I was thinking of the human species life span. Although there's people looking at ways we can extend our life span,

the human species, generally, even those of us that are pretty healthy late in life, living to 100, 105, that seems to be about it for humans.

Life expectancy refers to how many years on average you might live based on your current age. So at birth in the United States people have a life expectancy in their mid-70s to around 80, women living a little longer, usually, than men. But your life expectancy does change as you get older. So as you become 65 years old, your life expectancy for men and women is well beyond the 70s, on average. Most people who live to be 65 will live into their 80s. And we do expect to see more people with life expectancies that approach the human life span of 100 in the future.

Moderator: Great. Thank you so much, Dr. Warshaw. We have a ton of questions coming in, so I'm just going to choose a few more and then also am going to turn to our operator to ask for a few if anybody has any on the line. But let me first go to one for Dr. Allen. For Dr. Allen, there was a question about assessing fall risk. The question was what about pain or opiate medications and alcohol usage in assessing fall risk?

Kyle Allen: Oh, thanks, Renee, that's a great question. Didn't go in down into the details. That would be one of the for-sure things that you want to assess, particularly either alone, either by themselves, whether people are taking pain medications, or particularly if they're mixing the two. And alcohol and screening for alcohol use in older adults is really, really important. And there's -- and kind of debunking some of the stereotypes, too, oftentimes getting older and loss, sometimes people use alcohol as a self-medication. And so screening for alcohol use and particularly the use of opiates and particularly the combination of alcohol and opiates as well as other drugs is really, really important. Very good question.

Moderator: Terrific. Thank you so much, Dr. Allen. Here's a question for you, June. It's actually a multipart question, but I'll sort of take a few of the pieces out of it. A lot of questions about the evidence-based community programs you discussed. So one question about that was where to find empirical literature about those programs, and what are the preferred methods of educating the elderly population on the services, community-based services available to them?

June Simmons: I guess those are separate questions. The evidence-based programs, many have come out at Stanford, Dr. Kate Lorig, and you can look at their -- at her website at Stanford and you'll find a whole portfolio of general self-management and disease-specific self-management. They are all six-week workshops that are led by peers, so they are not led by health professionals. They are all trained in a four-day, full-time training program by master trainers who are trained by T-trainers, so it's a highly structured, scripted structured approach that's based on motivational interviewing kinds of systems with goal setting, action plans and peer support.

They're quite powerful. They get very good results. They're not health education, they're patient activation. And they are to be found typically through your state department of aging and state department of public health. Your local area agency on aging, senior centers typically have been now encouraged and they have some funding to provide these, and they're -- right now they're also being tested in California by Blue Shield of California for their exchange patients under the new state insurance exchange under the Affordable Care Act.

There are others that are specific for caregivers that could be found on the Alzheimer's, National Alzheimer's Association website, and many can be found on the Administration on Community Living website in the federal government, and also the National Council on Aging, NCOA.org, has a Healthy Aging website that has tons and tons of these resources. So they're widespread and they're high impact.

And how do you get information about community resources? There is a move to use area agencies on aging, and Kyle, I think, is quite the expert on marrying medicine and these kinds of resources. He might want to comment, because he's developed one of the most elaborate models in the country very, very early. He's a true pioneer in this area. But these models are spreading now because many people turn to their physician for help on aging issues, but many turn to their senior center, and there's an entire national infrastructure under -- in each state under the department of aging. Federal funding from the Older Americans Act flows down, and there are a whole host of resources then that are available to patients. And these are the agencies to partner with to build this kind of community service into a direct connection with your practice.

Moderator: Thank you, June. I wanted to just turn quickly to the operator to see if there were any participants that wanted to ask a question over the phone line. Doug?

Operator: It appears that there are no phone questions at this time.

Moderator: Okay. Then I will put one more question out there. The question came in from one of the few home care folks that were on the call. He or she asked for someone to discuss the interaction of the social worker or social services approach with home care workers.

June Simmons: Well, this is June, maybe I'll take a crack at that, although the others may also. Kyle probably has a lot of thoughts about this. He's got this tremendous long-term perspective as a physician. But often the assessment that I reference that is kind of classic when we're not sure what's going on with someone and we need to know who we're dealing with and what's getting them in trouble, they may then find a tremendous need for the home care worker.

The home care worker may come through public sources or private sources, because these are not just -- social work doesn't mean people are poor. It means they're social. So these are universal human needs. But if people are low income and they're getting publicly supported personal care at home, they may need more hours, and these kinds of programs can identify and advocate for that.

But the home care worker also plays a key role, because they're there on an ongoing basis monitoring, just like the Meals on Wheels person who drives through. So I know we will be seeing an expanded reliance on these important sources of information since what we want is Goldilocks care -- not too much, not too little, the just right amount. Then we want to catch changes in condition early and jump on them when the most can be done about them with the least resource and the least suffering. The home care worker is in a unique position to catch and report that. So they have a very important role emerging as our whole delivery system evolves and changes.

Moderator: Great. Thank you so much. I'm sad to report that we've come to the end of our time together.

First I wanted to take a moment to, of course, thank our speakers and everyone else on the call for your time and your participation. We're absolutely thrilled that you could join us and really appreciative that you find the topic to be of interest and relevant to your work.

If you would please take a couple of minutes after we finish the presentation to complete a final survey about the webinar so we can continue to provide quality webinars, we'd very much appreciate it.

I wanted to remind you of a few things. If you have any questions or comments, please email them to RIC, that's Resources for Integrated Care or RIC@lewin.com.

Again, the webinar presentation has been emailed, I understand, to all of you and is also available for download from ResourcesforIntegratedCare.com.

As I mentioned before, we received many, many questions that we did not get to, so anything we didn't get to will be posted with the question and the answer next week on Resources for Integrated Care.

And, finally one last note, we hope that you'll join us next week for the second webinar in this series. We'll be hearing a discussion next week on geriatric assessment, digging a little deeper than we did today. I know we alluded to it several times, but we will be digging even deeper into the topic, and that will be happening on Thursday, August 28, from noon until 1:15, same time as this one.

So that concludes our webinar. Have a great afternoon. And please do answer the -- take a few moments to answer our survey.

Operator: That concludes our conference for today. Thank you for your participation and for using AT&T Teleconference Service. You may now disconnect.