



HMOs' CONTINUUM OF CARE

Because they can oversee all aspects of the continuum of care, health maintenance organizations (HMOs) are particularly well suited to serving elderly clients, according to speakers at the March meeting of the American Society on Aging in San Diego. As healthcare organizations begin to offer more services themselves or collaborate with others to expand their services, they can learn from the experience of managed care providers.

This article discusses how two HMOs and one social HMO (SHMO) target their services to meet the needs of the elderly.

KAISER: UNIQUE USE OF PHYSICIANS

Kaiser Permanente in San Diego has an approach to the continuum of care that works within its managed care environment but could be adapted to other settings as well. The unique feature of the San Diego program lies in how it uses physicians, according to Lisa Heikoff, MD, a geriatrician in the Department of Continuing Care Services.

"We have board-certified geriatricians whose sole responsibility is in the long-term care/home healthcare/hospice spectrum," Heikoff explained. "Thus they are not pulled in six directions at once and are more satisfied with their jobs." She noted that the San Diego program is unique even within the Kaiser Permanente system; the system's various regions all have differing structures and ways of handling long-term care.

Kaiser-San Diego's Department of Continuing Care Services integrates healthcare providers with more traditional hospital services such as discharge planning and placement coordination. The department also encompasses social services, rehabilitation, care management, geriatric assessment, and Women Creating New Lives, a pro-

How HMOs

Target

Their

Services to

Meet the

Needs of

The Elderly

gram for pregnant women who are chemically dependent.

Having all these services in the same office, Heikoff suggested, facilitates good patient care and planning for the future when a patient leaves the hospital. When a patient goes into hospice, home care, or a skilled nursing facility (SNF), one

Summary As healthcare organizations begin to expand their services to serve the elderly, they can learn from the experience of managed care providers.

Kaiser Permanente in San Diego, a health maintenance organization (HMO) integrates healthcare providers with more traditional hospital services such as discharge planning and placement coordination, as well as social services, care management, and rehabilitation. Having all these services in the same office facilitates good patient care and planning. When a patient goes into hospice, home care, or a skilled nursing facility, one of four physicians takes on sole responsibility for his or her treatment and continuity of care.

Group Health Cooperative of Puget Sound, Seattle, is a consumer-governed HMO. Group Health makes decisions based on data about enrollees plus input from medical staff and senior groups. It emphasizes putting the right services with the right consumer using subgroupings based on functional status: healthy, moderately frail, and frail.

Seniors Plus, a social HMO in Minneapolis, integrates acute and long-term care. Providers determine who needs functional assessment and care management by looking first at the diagnosis, then the severity of impairment and comorbidity, other medical problems such as depression and falling that indicate a need, and finally limitations in function and ability to perform activities of daily living.



of four physicians takes on sole responsibility for his or her treatment and continuity of care. The physicians spend 50 percent to 75 percent of their time taking care of nursing home patients and the rest caring for hospice and home health patients. The long-term care division serves 400 patients in all.

The physicians work with four nurse practitioners and a physician assistant, all with geriatric training, Heikoff said. The nurse practitioners see the patients a minimum of once a month (sometimes daily), and physicians see acute patients at least once a week and chronic patients once a month. The physicians are on call routinely, so they are familiar with all nursing home patients. Because the discharge coordinator is a member of both the long-term care and discharge planning divisions, the healthcare team can anticipate patient needs long before they leave the hospital.

Heikoff added that Kaiser's utilization management staff visit the SNFs for weekly conferences to decide when therapy in a SNF should stop—when patients should move on to a custodial level or receive home healthcare. She noted that utilization management is separate from discharge planning, and the personnel report to a different command. "I think that's a good balance," Heikoff said. "It provides discharge planning with a little more freedom to really look at clinical situations and psychosocial needs," rather than feeling intense pressure from the "higher-ups" to reduce patients' hospital stay without worrying whether their needs are being met.

KAISER'S FUTURE PLANS

Kaiser Permanente in San Diego is working toward a model of a broad-spectrum care management, which Heikoff referred to as "the lynchpin, the tie that binds all services together." Kaiser just received a Garfield Grant to develop an outpatient geriatric assessment and care management program. Such a program would take patients into the system at multiple points—after hospital discharge, after home health discharge, and after SNF discharge—as well as covering frail outpatients.

"What we need to do is pick up those patients who fall through the cracks," Heikoff said. She noted that Kaiser's home care and hospice programs are well established but still do not take care of everyone. They pass over, for example,



One problem facing healthcare facilities seeking to serve the elderly is how best to use geriatricians, since these are a scarce resource, Heikoff said.

people who have finished their home health services but are still in need of some ongoing supervision and assistance, or people who have many social problems but still are not ready to move on to a hospice level of care.

THE SHORTAGE OF GERIATRICIANS

One problem facing healthcare facilities seeking to serve the elderly is how best to use geriatricians, since these are a scarce resource, according to Heikoff. She noted that only 120 or so board-certified geriatricians graduate each year nationwide. "Gerontology is not sexy; it's not reimbursable; and I don't imagine that there's going to be any huge influx of board-certified geriatricians in the future, unfortunately," Heikoff noted.

She added that putting geriatricians in clinics to give hands-on treatment to chronic, entrenched geriatric patients is not using their skills to best advantage. Instead, she recommends using geriatricians as consultants in outpatient multidisciplinary geriatric assessment programs that give feedback to the primary care provider through ongoing care management. Another suggestion is using geriatricians as educators for physicians such as orthopedists, surgeons, and internists. "If someone is not a board-certified geriatrician, then they need a lot of training before they can work in long-term care," Heikoff claimed.

GROUP HEALTH: A CONSUMER-CENTERED HMO

A different type of HMO with an extensive program to care for the elderly is Group Health Cooperative of Puget Sound, Seattle. Group Health is unusual in that it is consumer governed, said Barbara Boyd, associate administrator of community health and long-term care.

Consumers are involved in Group Health through the Senior Caucus, a strong advocacy group with members on the home care advisory board and other Group Health committees, Boyd noted. The caucus also sponsors educational programs and addresses legislative and public policy issues. "They are truly the voice of the customer in giving us feedback on the direction we're taking with senior services," said Philip Nudelman, PhD, Group Health's president and CEO. In addition, the Senior Caucus is involved with senior volunteer services, an information line, and peer counseling.

The HMO has 470,000 enrollees in a seven-



county area. Group Health staff collect a lot of data on these patients to see where the organization might increase or change services, Boyd noted. They have found, for example, that the 11 percent of enrollees who are Medicare eligible use 32 percent of the services, including six times the number of hospital days and twice the outpatient visits as other clients.

Group Health makes decisions based on such data plus input from medical staff and senior groups. Its services are in transition because of the growing senior population and cost and utilization issues, said Boyd. Group Health has just formed a senior care planning group to try to bring all the services together in a systemic manner, but it has a long way to go, she added.

"Planning for seniors requires that we put more specific emphasis on the subgroupings based on functional status—healthy, moderately frail, and frail," Boyd explains. "The concept of appropriateness requires that we put the right services with the right consumers" (see **Box**).

Group Health makes decisions based on enrollee data plus input from medical staff and senior groups.

SENIORS PLUS: TARGETING POPULATIONS

Targeting specific groups of older persons is the most important goal at Seniors Plus, Minneapolis, according to Tom VonSternberg, MD, the social HMO's (SHMO's) medical director. SHMOs are an integrated approach to acute and long-term care for the elderly. They expand coverage of nursing home and community-based care and link these services with a complete acute care system, generally using care management.

In a typical elderly population, VonSternberg said, 80 percent will be well, independent, and functioning, and 15 percent to 20 percent will have varying degrees of impairment. Successful integration of acute and long-term care requires "targeting your energies and your resources to those individuals who need them so that you're ready to provide care when they fall into a new category of impairment," he added.

To determine who needs functional assessment and care management, VonSternberg recom-

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SERVICES FOR SENIOR SUBGROUPINGS

Group Health Cooperative of Puget Sound, Seattle, has different approaches to serving subgroups of the elderly population, Barbara Boyd explained at the American Society on Aging's March meeting.

HEALTHY ACTIVE SENIORS

Healthy active seniors are mobile, respond well to classes and group programs, and can be given information through Group Health's magazine. The main goals are prevention and education to help them stay healthy. The clinic-based primary care services can usually meet their needs; they use the hospital infrequently and may require only a week or two of home care.

Three interventions are particularly helpful with this group, Boyd noted: pharmacist review of medications, patient education by nurses, and an educational approach to mental health. Educational programs emphasize health promotion, such as senior exercise and

smoking cessation classes and a "normal aging" workshop so patients can be partners in healthcare by understanding issues such as the effects of aging on mobility, the role of exercise and nutrition, pharmacy issues, and the importance of planning ahead.

A resource line manned by 25 volunteers provides information on services and educational opportunities through Group Health and within the community. Group Health also has a senior center, flu vaccination programs, phone visitors (volunteers who call the socially isolated once a week, reducing inappropriate use of services at clinic level), and a senior housing cooperative.

MODERATELY FRAIL SENIORS

Moderately frail seniors are somewhat higher risk than the group just described. They need more supportive services such as home care and use clinics more frequently. The clinics have geriatric assessment units and geriatric

residency program, so some geriatricians give hands-on care. Group Health also reaches this group through in-home assessments and education by staff, which includes the use of pamphlets. A home and community volunteer program helps meet this group's need for errands and their care givers' need for respite.

FRAIL SENIORS

Boyd identified several opportunities for improving services to frail seniors:

- Identify care givers in the home
- Develop an approach that includes attention to the functional side and helps the person maintain independence
- Create alternatives to institutional living
- Ensure high-quality skilled nursing care in an SNF "that attends effectively and humanely to posthospital, transitional, rehabilitation, and terminal needs of the frail seniors"

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mended looking first at the diagnosis. Problems such as dementia, Parkinson's disease, arthritis, chronic obstructive pulmonary disease, atherosclerotic cardiovascular disease, vision and hearing deficits, and obesity may indicate a need for care management, he said.

In addition, VonSternberg advised providers to look at the severity of the impairment and at comorbidity—much harder elements to assess. He said that some specific clusters of diagnoses are more indicative of the need for intensive use of services, but these are hard to define. Other medical problems that may indicate a need for care management are depression, falling, incontinence, decubitus ulcers, and hip fracture, he said.

In addition, a functional assessment is needed to determine limitations in function and ability to perform activities of daily living. "What we're going to try to do is literally change the whole approach of a system from that of an acute care, single problem-oriented diagnosis and cure standpoint to one that is functionally based," he said. Rather than viewing cure as the major priority, VonSternberg advised using treatments that maximize function at home. "That's a huge quantum shift for people in the medical world," he noted. "The role of the care manager is to change the dialogue, to change the orientation."

To bring the medical sphere closer to the long-term care one, providers can look at functional symptoms, VonSternberg said. They can frame the description of a person's medical disease in terms of the deficits symptomatic of that specific disease. From such a perspective, for example, the problem would not be heart disease or arthritis, but weakness, decreased endurance, poor balance, poor memory, and poor judgment, he said. "These are the things that result in people not meeting their day-to-day needs."

—Susan K. Hume

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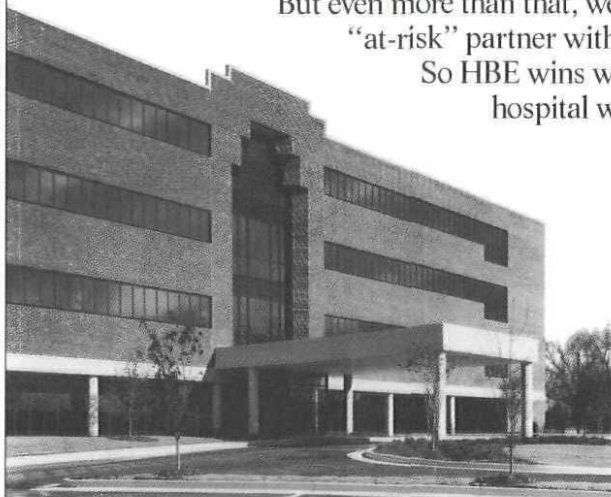
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