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Huntington Hospital Senior Care Network

Perspective

A NEWSLETTER ON AGING AND SERVICES *for* OLDER ADULTS

The Promise of Healthcare Change: *An Interview with Stuart Miller, MD*



Stuart Miller, MD, is a physician in internal medicine with Huntington Medical Foundation in Pasadena, California. He has been in practice since 1980. Dr. Miller is also vice president of the **Huntington Care Network** Accountable Care Organization (ACO), a partnership between **Huntington Memorial Hospital** and community-based primary care physicians to help improve the quality of patient care.

Perspective: You have seen many changes in medicine. What impact have these changes had on primary care physicians and their relationship with patients?

Dr. Stuart Miller: We're seeing more of a team approach to general medicine and in patient care. Doctors no longer function in individual silos. I think it's the right way to go — to increase transpar-

ency and communication among all the providers. It's not just with doctors, but with nurses, physical therapists, social workers, even the volunteer department in the hospital. My practice now is mostly outside the hospital walls. I need better communication with outside providers such as skilled nursing facilities and home healthcare agencies. It's a better relationship overall. >

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With patients, it's important how you present this evolving approach to them. The changes are new to them and to us. The patient is the owner of the team, and we do need more communication with the patient, their family and intimate friends. My role is to be the advocate of the patient. I'm the manager of the team.

You work closely with Huntington Hospital. What is the value of that relationship?

Not only has the hospital been a great team player, but also we are very lucky. We have doctors who communicate and the nurses are extremely helpful. I'm amazed how everybody is stepping up. Early on, Huntington Hospital was an exceptional hospital. It's what drew me here. The mood and the feeling you get is warm and caring. That's not always what you get in hospitals. And you can't learn that in school.

Primary care physicians and the hospital are seeing a greater number of patients with chronic disease. How do you break the cycle of repeated hospital and emergency department visits that often occurs with these patients?

This is a key concern of the Huntington Care Network ACO, and a large and often inappropriate expense. We want to give our patients better options — better for their care, their pocketbook and for them in general. We have to offer better access to doctors in the office and to urgent care.

We are exploring the idea of a chronic disease center so we can be more proactive. Whether it's for patients with diabetes, congestive heart failure or other chronic conditions, the center would not compete with primary care physicians or specialists, but enhance their role. It would include ancillary extenders such as dietitians and nurse practitioners. Doctors

would continue to see the patients in their office, but for those patients whose disease is not super-controlled, then the center could offer timelier follow-up and education. We could intervene sooner and hopefully prevent some emergency department visits and hospital readmissions.

How does the ACO view community-based services?

They are essential! Patients come to the emergency room on Friday, but can't get the medicines or medical equipment they need until Monday. They can't make it that long and end up back in the ER. Maybe they needed a ride to get the medications or they had questions and didn't know whom to call. This is where our hospital health navigators and social workers come in. They can be sure patients can get their medications and have a phone number to call.

The ACO is not an HMO, but its purpose is to help coordinate all services. It's no longer enough that we have an outstanding hospital. We have to look to our community providers and make sure they are superb. Thirty years ago I didn't think about providers being everyone who has a finger in this patient care recipe, especially the out-of-hospital community providers' involvement.

The ACO hopes to improve care coordination among multiple providers and various settings. What are the challenges?

We must educate everybody — patients, doctors, specialists and everyone who gives care to our community. The ACO is confusing and there is mistrust of sharing data, yet it will help us all work together more closely in providing truly patient-centered care. We need to involve everyone, ask for their input and give them some buy-in. That includes everyone >

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in the hospital, from the transport and maintenance personnel to the person in admissions. Patients remember if they are greeted with a smile, if the water temperature is too hot or the food is cold.

Setting up infrastructure is another vital challenge — how to get the pieces lined up so we have “All-Stars” on our team. It will take time and feedback to have smoothness in our flow and not drop the ball. But it’s really exciting and that’s why I’m taking an active role.

Where does Senior Care Network fit into the ACO?

Senior Care Network is an essential team member that can help seniors avoid unnecessary emergency department, hospital and nursing home care by reaching out to them in their homes. Their ability to assess the needs of the individual and their family, and give them education and community resources, is important to keeping patients healthy and safe. Also,

their collaboration with the health navigators and healthcare team not only helps address patients’ needs, but helps ensure the continuity of care as well.

Will the ACO benefit all patients?

The focus of the ACO is Medicare fee-for-service patients, but everything we’re putting together and the lessons we learn apply to every patient. If I can help one or two patients with diabetes early, then maybe when they’re older, the costs will be less. I don’t see any downside to the ACO. We have the pieces and the players and we’re in it for the long haul. The old way was good for the past, but the question I ask, when looking toward the future, is: Can we be even better? ‡

How Care Coordination in the Home Enhances Independence

The connection and trust established through in-home visits by the care coordinator help ensure that vulnerable clients have the support they need.



When frail elderly individuals can stay independent and avoid premature placement in a nursing home, everyone wins – the individual, the family and a healthcare system struggling to rein in costs. The ***Multipurpose Senior Services Program (MSSP)***, a publicly-funded program for low-income frail elderly that provides care coordination in the home, is a proven model that works to achieve just that.

Key to its success is the personal connection established between the care coordinator and the client and family through in-home visits in addition to telephone monitoring. For a vulnerable population burdened with chronic

disease and at high risk of medical crises, face-to-face contact has been essential to ensuring safety and well-being.

The story of Mrs. M, 81, illustrates how a trusting relationship developed with the care coordinator can reduce risks and allow frail seniors to remain in their own home. A widow with a history of hypertension, osteoporosis and falls, Mrs. M also coped with mobility and speech difficulties due to a stroke. She was referred to Huntington Hospital Senior Care Network (HSCN) after hospitalization for yet another fall and was enrolled in MSSP. Her children did not live in the area but kept in close contact by phone. She was already receiving in-home assistance and seemed to her family to be content.

During initial home visits, Mrs. M told the care coordinator that she



By seeing Mrs. M in her home, the care coordinator was able to observe Mrs. M's functional abilities, suggest workable solutions to problems and confirm her understanding despite her declarations that everything was fine.

was doing fine but did ask for help to get an emergency response system, a podiatry appointment and to replace some unsafe furniture in her home. Further visits revealed that Mrs. M, determined to be independent, was too embarrassed to tell her family of her needs, despite their willingness to help out if she had asked. Instead, she had kept many concerns to herself. "I don't want them to worry about me," she would say.

Mrs. M became comfortable with the care coordinator's visits and agreed to let the care coordinator inform her family of her needs. "She knew she had limitations but she found it easier to accept our help than that of her own family," the care coordinator noted.

The family was surprised when they learned of safety issues and recent falls that had left Mrs. M in pain, but they welcomed the information. "She values you more than what we say, so we are glad you can help us help her," they told the care coordinator.

By seeing Mrs. M in her home, the care coordinator was able to observe Mrs. M's functional abilities, suggest workable solutions to problems and confirm her understanding despite her declarations that everything was fine. "She was afraid if she made many mistakes, her family would insist she move," the care coordinator re-

marked. "By engaging in non-judgmental, non-threatening conversations about what was realistic and what was not, I could help her decide what was safe."

As Mrs. M became more open about her fears and concerns, the care coordinator learned that she had signed several legal documents without understanding their meaning, putting her at risk for loss of public benefits and exposure to fraud. The care coordinator helped her resolve the issues and Mrs. M agreed to get help from her trusted sources first before signing any documents.

Mrs. M may move in the future, but she knows she can discuss the pros and cons with the care coordinator and that her family is willing to support her wishes if possible. The connection and trust established through in-home visits have helped ensure that Mrs. M and her family have the support they need.

"Too much would have been missed if we had just related by telephone," the care coordinator maintains. "Home visits have allowed fuller determination of her situation and needs and what has been necessary to help her address her safety concerns at home." †

In MedCHAT sessions throughout California, participants worked together using a computer process called CHAT® to design the best Medicare coverage possible for everyone in the country.



Photo from the California MedCHAT Collaborative, used with permission from the Center for Healthcare Decisions.

Innovative Discussion Elicits Community Input on Medicare Changes

If you could have Medicare your way, what would you change? That's the provocative question put to 25 community residents who attended MedCHAT sessions presented by Huntington Hospital Senior Care Network (HSCN) in partnership with the **Center for Healthcare Decisions, LeadingAge California** and a coalition of agencies.

Part of efforts to involve the general public in a national debate on Medicare reform, the **California Medicare CHAT Collaborative (MedCHAT)** engages individuals in an interactive discussion using a computer-based process called CHAT® for designing Medicare cover-

age. "We know Medicare needs changes and this is a way for individuals to speak up about it in a safe setting," says Kristen Tachiki, MSW, HSCN care coordinator who co-facilitated the sessions.

Working at computers in groups, participants were asked to create a benefits package where coverage options exceed current Medicare funding. With many demands vying for finite resources, choices had to be made.

"There are only so many slices in the pie," notes Tachiki. "They had to decide as a group what to spend the Medicare dollars on. Do you choose to have a limited range of physicians to see in exchange for eyes, ears and teeth coverage? How much do you spend on medical treatments >

Medicare is one of the most pressing topics in the national dialogue on healthcare policy. The number of beneficiaries is expected to grow from 54 million to 80 million by the year 2030, and many are concerned about its long-term financial health.

~ *Re-Designing Medicare: Findings from the California Medicare CHAT Collaborative*

for end-of-life care? There's no right or wrong choice."

Older adults from a range of ethnic and socioeconomic backgrounds and employment status took part in the sessions. After they worked on a Medicare plan for themselves and for the whole country, they debated their choices and justified tradeoffs in an extended discussion with the entire group to create one uniform plan. They then made their final decisions on a Medicare plan for the country.

Their input is incorporated into a September 2014 report, *Re-Designing Medicare: Findings from the California Medicare CHAT Collaborative*, which covers 82 MedCHAT sessions conducted in the state over the past year. The report shows that participants took their redesign task seriously. A large majority increased Medicare coverage for five categories: long-term care; dental, vision and hearing; transportation for medical appointments; mental health; and Medicare's longevity. In return, they did not eliminate benefits but added new restrictions: mandatory enrollment in a

provider network, reduced coverage of low-value care; change of coverage for end-of-life care; penalties or rewards to urge patients' compliance; and charging higher-income seniors more for Part B premium.

Like other participants, HSCN's groups agreed that the MedCHAT experience improved their knowledge of Medicare and gave them food for thought. They know healthcare is changing and they will feel the effects in the future.

"I think they came away realizing we can't fund everything and the give and take is what's most important," Tachiki says. "Medicare is a timely topic and this gave the community information and a platform to talk about what it means to them. It provided an important service." †

Keeping Clients *Connected to the Community*

Blanca Paroda, a client in HSCN's Assisted Living Waiver program, which allows frail older adults to reside in an assisted living facility as an alternative to a skilled nursing facility, enjoys living in the community where she can easily socialize with others.



Huntington Hospital Senior Care Network (HSCN) programs that link frail seniors to services such as meals, housekeeping and in-home assistance help them to live safely in their own home. But successful aging in place also means addressing the social isolation and disconnect from the community that disability and frailty can bring.

Research continues to document how lack of socialization and community connections can affect physical and mental health. Reports such as the Robert Wood Johnson Foundation's *Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health*, in which four in five surveyed physicians say unmet social needs are directly leading to worse health, underscore the essential role of connections in keeping people healthy.

For HSCN care coordinators, assisting clients in developing social connections is part of helping them maintain well-being. Life events and illness can all too easily disrupt social connections and increase isolation. When Mrs. W, who at age 76 is limited by chronic health conditions, lost her husband, she not only was grief-stricken but had to move in with her sister who was at work all day. She became deeply depressed and cried most of the time. The care coordinator linked her to adult day care where she made new friends and received counseling. Within a short time her mood had improved dramatically.

"When people are truly independent in their home, they have a range of contacts," says Chris Garcia, LCSW, HSCN clinical supervisor. "Family provides a certain >

kind of interaction and community provides another, whether it's through a senior center or a church. It's very individual for each person."

Finding the right connections can be challenging, but they are invaluable when achieved. A client with mental health problems was very isolated until her care coordinator helped her make the choice to attend a structured psychiatric day program that provided an art class, group participation activities and holiday parties. "It's made a huge difference for her, but she needed to be motivated and would not have gone on her own," the care coordinator noted. "She goes five days a week now and has been enjoying it for years."

Another client loved to play bridge but couldn't find anyone to play even gin rummy with at the facility where he lived. The care coordinator located a bridge club at a senior center and the client was overjoyed. "He didn't think of himself as a senior citizen and never thought about a senior center. Now he's very involved in activities and connected with people like himself who want to remain active. He's very grateful," the care coordinator reported.

By encouraging clients to utilize community resources, the care coordinator is often the spark to restoring meaningful connections with others. Benefitting from strategies such as locating transportation to go to church, finding a community setting where people speak their native language or, for homebound clients, connecting them with a friendly visitor program or in-home counseling if they are depressed, clients have become less isolated and more engaged.

"The concept of aging in place doesn't go far enough," asserts HSCN director Eileen Koons, MSW. "It's important in a client's care plan that we consider what resources and services can help a person attend to quality of life, to find joy and purpose and be excited to get out of bed each morning. It's about the individual as a person." ‡

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*Huntington Hospital Senior Care Network provides access to a complete range of medical, social and personal services for adults and older adults with disabilities and their families. Support comes from public and private funding and proceeds from **The Huntington Collection**. For more information, call (626) 397-3110 or (800) 664-4664 or visit our website at www.HuntingtonHospital.com/SCN.*

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