COMMUNITY LTC

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A Path To Building Accountable 'MediCaring' Communities

Two years ago, Joanne Lynn, MD, wrote: "Medicare 2014 has achieved the main goal of Medicare 1965. Nevertheless, the system designed for the priorities of 1965 does not match the needs of 2014, and beyond. Addressing needs and correcting course to change habits of overtreatment and cost inflation for older people living with multiple chronic conditions is a historic opportunity to build Medicare 2030."

Dr. Lynn's vision and call to arms for Medicare 2030 have been described in a recently published book, *MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost.* An article that details a financial simulation of that model recently appeared in *The Milbank Quarterly.*

Joanne Lynn

Along with other models we have reviewed in this column — PACE (Program for All-Inclusive Care of the Elderly), GRACE (Geriatric Resources for Assessment and Care of Elders), and the VA's Home-Based Primary Care — the focus of Dr. Lynn's advocacy has everything to do with community-based long-term care.

Dr. Lynn's name, face, and voice are familiar to the Society as a geriatrician, hospice physician, health services researcher, quality improvement advisor, and policy advocate. She has published more than 250 articles and 12 books. In 2013, she delivered the closing address on "Health Reform for When We Are Frail and Old" at the Society's annual meeting. A number of years ago, she delivered the Anne Marie Filkin lecture at the annual meeting on improving care for the end of life.

She has been a consultant to the administrator of the Centers for Medicare & Medicaid Services, faculty member for the Institute for Healthcare Improvement, a senior researcher at RAND, and currently leads the Center on Elder Care and Advanced Illness for the Altarum Institute.

With *MediCaring Communities,* Dr. Lynn offers a model intended to be more comprehensive and transformative in responding to the Institute for Healthcare Improvement's "Triple Aim" of improving the patient's experience of care, improving population health, and reducing the per capita cost of care. There have been many initiatives that show how to improve medical care and lower costs, but few are transformative enough, she would argue, to enable a much larger population of frail, elderly Medicare beneficiaries to live comfortably, meaningfully, and at a cost families and the nation can sustain.

Think "population well-being," and picture this huge cohort of baby boomers aging together!

There are six essential elements to the MediCaring Communities model:

- Frail elders identified in a geographic community
- Longitudinal, comprehensive, elder-driven care plans
- Medical care tailored to frail elders
- Scope to include social and supportive services
- Monitoring and improvement by a community board
- Financing with savings from Medicare.

There are two dramatic differences in this model compared with current practice. First, it's tailored to and designed around the individual. "Each frail elderly person has a unique set of hopes, priorities, strengths, personal resources, and medical conditions," Dr. Lynn told *Caring*. That suggests that an individualized, customized plan of care and services is necessary, not just the delivery of evidenced-based medical treatment. Second, this customized plan of care and services is anchored in the person's local community. The wide array of support services in the community enables people to live comfortably and meaningfully. Through some formal structure and process, the community should also co-manage improvement activities and funding strategies.

The model requires flexibility. Just as the individuals served need customized plans of care and services, the model acknowledges the unique needs of each location and each community in which it is implemented, and must be tailored to fit.

To that point, "MediCaring Communities is what some call an 'absorptive' model — all the good ideas shown in other initiatives can be implemented as they make sense — so long as they generally improve care, mesh well with other reforms, and save (or don't cost more) money," Dr. Lynn said. "MediCaring Communities has much to learn and borrow from other initiatives (e.g., GRACE, VA's Home-Based Primary Care, PACE), and they would all do better in a context in which overall outcomes are being monitored and priorities among expenditures are being managed."

Simulation Report

The last element of the model — financing with savings from Medicare – was the subject of the financial simulation reported in *The Milbank Quarterly.* The simulation model was developed with leaders from four diverse communities across the country as part of a joint proposal from the Center for Medicare & Medicaid Innovation.

The four communities — Akron, OH; Milwaukie, OR; northeastern Queens, NY; and Williamsburg, VA — were chosen for their adequate size, varying health care delivery systems, and ability to implement reforms and generate data quickly.

The findings of the simulation were dramatic. Projected third-year savings ranged between $269 and $537 per beneficiary per month and cumulative returns on investment between 75% and 165%.

Two key conclusions were drawn. First, the model did deliver care at lower or comparable cost to Medicare. Second, improvement to the overall health care system is possible if at least part of the savings is reinvested in the MediCaring Communities to bolster support services (such as nutrition and transportation) that elders need.

It was also noted that widespread implementation of the model would also require different approaches by government (CMS, specifically) and strategic foresight and partnership with key stakeholders at the community level. MediCaring Communities require waivers from CMS policies that currently prevent delivering services more efficiently, such as the rules that prohibit PACE and hospice providers from contracting to provide à la carte services. Waivers make it easier to have Medicare savings reinvested into the provision of support services like Meals on Wheels.

As both a practitioner and a policy advocate herself, Dr. Lynn said she encourages readers to be informed about and engaged in macro issues of health care and health care delivery; to know your community — its health care needs, and its strengths and weaknesses; and to stay committed to building the next generation of geriatric competency. Dr. Lynn is convinced that the good, innovative work done to date with community programs and structures is necessary, but isn't enough for transformation that's needed.

The MediCaring Communities model is gaining traction. Although the book's publication and the financial simulation reporting are very recent developments, Dr. Lynn said that there are a dozen or more communities moving toward the starting line of planning and implementation.

Dr. Lynn calls inertia the greatest barrier to change, and there are many facets to that, including the will to challenge current assumptions in the midst of the whirlwind of change, albeit sporadic and inconsistent, that is already taking place across health care.

She'd also suggest that you read *MediCaring Communities* and consider advocating for it.

Mr. Kubat is director of mission integration for the Evangelical Lutheran Good Samaritan Society. He is an editorial adviser for *Caring for the Ages*.