The Graying of Kaiser Permanente

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Summary

Permanente physicians and staff are part of a new phenomenon: Kaiser Permanente (KP) has never had so many older members living so long and with so many medical conditions. The logarithmic growth in technology and the concomitant heightened public expectations have created a menu of seemingly endless diagnostic and intervention choices. The practice implications of these numerous advances are not yet defined but are already being felt. Physicians are summing up the impact on their practice in an exclamation that echoes throughout KP: "I cannot do it all in 15 minutes."

The metaphors "Age Wave" and the "Graying of America" describe the changing demographics of both KP and America. Our KP Program currently has 830,000 members older than age 65 with 55,000 of them older than age 85. This number is expected to double in the not-very-distant future. Medical care for this population has economic, ethical, and social implications that seem overwhelming. What can KP do to prepare before this change is upon us, especially in the context of finite resources?

This article will describe what the Kaiser Foundation Health Plan (KFHP) and the Permanente Medical Groups are doing to address this challenge. Elder Care leaders at the regional and medical center levels, in collaboration with the programwide efforts of the Care Management Institute (CMI) Elder Care Initiative and the Kaiser Permanente Aging Network (KPAN), are taking steps today to help prepare the organization for the reality of tomorrow.

The Role of Older Adults in KP's Success

KP opened its doors to the general public the same year that the first baby boomers were born. This influential generation, born between 1946 and 1964, is currently gaining firsthand experience in the challenges associated with aging as they assume more responsibility for the care of their aging parents. They are simultaneously acquiring their own age-related conditions and functional limitations. There is strong consensus that "boomers" behave very differently from their parents in seeking health care and will demand new, better, and different kinds of health care for themselves as older adults. This generation transformed the way women give birth in this country; it is likely they will transform the way health care is delivered to older adults and the way they die.

KP's ability both to meet changing member expectations and to manage effectively the demands placed on the system by the sheer number of aging boomers seems inextricably linked to the long-term success of KP. Each year, Permanente physicians have more than 6 million office-based contacts with older adult members. Older members represent a disproportionate number of hospital days as well as a significant portion of ambulatory surgery, pharmacy, diagnostic, durable medical equipment, skilled nursing facility (SNF), home health, and hospice services.

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KP's over-65 membership currently comprises only 10% of total membership, but their care accounts for about 30% of costs. Membership, costs, and revenue vary across the KP Program and within its regions. In the KP Ohio Region, the percentage of membership comprised by over-65 members already is approaching 20% (Figure 1). In some service areas and medical offices in other parts of the KP Program, membership is already in the high teens. At some offices, older adults daily comprise more than 70% of visits. Ophthalmology, orthopedics, urology, neurology, dermatology, and many other specialty areas provide care for these members.

As a program, KP must influence policy, maximize revenue, and manage care, costs, and quality for

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today's members. At the same time, KP must redesign core aspects of health care delivery for a membership that will soon grow to 20% of KP total national membership. Uncertainty about future Medicare products and revenue makes this work extremely challenging—but all the more important.

Diversity of Function and Need

Older adults exhibit a diversity that goes beyond the more traditional concepts of ethnicity, gender, culture, and race. Biology, cognition, physical functioning, functional reserves, social roles, support systems, finances, and worldviews are some of the characteristics that contribute to the richness of their diversity. This diversity requires varying levels of support and interaction with family, friends, community, government, society, medical care, and care coordination. Traditional medical delivery, with its evolution as an acute and reactive model, is inadequate for the complex needs of many older adults.

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Innovations in Elder Care

KP has a rich history of building and testing new models of care for older adults. In 1967, the US Public Health Service funded a demonstration project at the KP Northwest Region's Center for Health Research on the use of post-hospital nursing home care and home health services. By demonstrating how people without financial resources could be brought into group care, this project led to the prepaid Medicare program.

In the mid 1980s, Kaiser Foundation Health Plan (KFHP) and KP leaders formally acknowledged the importance and implications of the impending demographics and established the Interregional Committee on Aging (IRCOA). They charged IRCOA to develop strategies and approaches to organizing and managing care for the projected increasing numbers of older adult members. IRCOA made many contributions that continue to serve as the foundation for current work. IRCOA's work focused on clinical care, financing, and policy, and its membership included leaders from KFHP and from KP. IRCOA was among the first groups to think in terms of populations and the approaches necessary for population management; and developed an identified network of committed and innovative leaders and clinicians throughout KP by sponsoring three Geriatric Institutes during the 1990s. IRCOA developed and recommended a "Model of Care for Elders" built on the principles of screening, assessment, and care coordination.

IRCOA's continuing role came into question when its coleaders, Mitch Greenlick, PhD, from the Center for Health Research, and Toby Cole, MD, Executive Medical Director of CPMG, both retired.

A Priority Population for the Care Management Institute

In 1999, the Care Management Institute (CMI) identified older adults as a high-priority population. This approach was novel for CMI; its earlier work focused on populations that were united by conditions or diseases. CMI had to expand the more traditional, evidence-based approach for several reasons:

- The disease model did not adequately address the diversity described above;
- No easily accessible automated metrics existed to monitor performance improvement;
- Older adults often had multiple serious comorbidities; and
- KP Regions had varying strengths and different priorities in addressing the care of this population.

CMI's focus on older adults was in ascendancy at the same time that IRCOA's future became uncertain. CMI polled the regional leaders of IRCOA, and a strong consensus emerged that the existing work and the Elder Care Network were valuable assets that needed to be preserved and expanded. IRCOA looked to CMI to coordinate this work.

Two major phases of work emerged in CMI's Elder Care Initiative. The first phase addressed the following areas: population screening and follow-up interventions, compassionate end-of-life care, and skilled-nursing-facility care. Work on care at points of transition was briefly addressed but was not developed, because of paucity of evidence and lack of promising models. Instead, work focused on medications that have special risks for older adults because of their association with cognitive impairment or falls. The *Elder Care Source Book* is the published result of this work.[a]

CMI's second phase of work in elder care more fully developed end-of-life care by identifying promising programs and models for managing advanced illness and by documenting those programs in the *Palliative Care Source Book*.[a] In addition, rigorous evidence review

[a]CMI resources for elder care

- Elder Care Source Book
- Palliative Care Source Book
- CMI Dementia Guidelines
- CMI Dementia Care Program

You can find these resources on the Permanente Knowledge Connection at: http://pkc.kp.org/.

Key Points for Dementia Diagnosis and Management

- **Early diagnosis matters**
- **There are things you can do to help**
- **Caregivers need support and assistance**

Screening:

Although routine screening of all older adults is not warranted, use of a quick, sensitive screening tool like the clock-drawing test or Mini-Cog can be used for older patients with a suspicious clinical presentation or for "older old" patients (ie, ≥ age 80). These can be completed in a minute or so and can establish a baseline for later comparison. If a patient fails screening, further assessment is warranted.

Assessment/Diagnosis:

Assessment for dementia involves gathering information over time to rule out other causes and to identify possible etiology. Full evaluation should be done for people who fail a screening test and for those who have a complaint of memory problems. Patients and their families must be informed about the process and what the different steps will tell. The assessment includes:

History – including symptoms, medical conditions, medications, family and social history

Clinical Exam:[a]

- ***Physical exam***—pay attention to patient appearance/behavior, focal neurologic signs (gait, balance, strength), hypertension, and extrapyramidal signs
- ***Functional status assessment***—measure using a tool like the FAQ (Functional Activities Questionnaire)
- ***Cognitive status assessment***—assess using a tool like the MMSE (Mini-Mental State Exam)

Laboratory Tests—including CBC, sodium, potassium, creatinine, calcium, glucose, thyroid test (TSH first), vitamin B12

Neuroimaging—Noncontrast CT is an option for all and is recommended for those under age 65 or for those over 65 who have atypical presentation, rapid deterioration, history of head injury, etc.

Management and Plan of Care:

Once the diagnosis of dementia is made, clinicians should

- Educate the patient and family about the diagnosis and management approach.
- Discuss how the disease will progress, and ensure that the patient completes an advance directive and designates a decision maker. This planning should be approached in the context of establishing preferences and goals.
- Refer patients and families to internal or community resources for additional education and support.

Acetylcholinesterase inhibitors, such as donepezil (Aricept®), may be useful for temporarily and modestly improving function in some patients with mild to moderate Alzheimer's disease. Patients receiving these agents should be reevaluated after 8-12 weeks, then every 3-6 months, to determine if the drug is adding any value. If benefits (including improvement or slowed decline) are not seen, the drug should be stopped.

No other agents (estrogen, NSAIDs, vitamin E, ginkgo biloba, statins) have been proven effective either in prevention or management of Alzheimer's disease or other types of dementia. ❖

[a] Consider alternate diagnoses—including depression and delirium.

For a more complete summary of the key components of screening, assessment, and management of dementia, go to http://pkc.kp.org to see the full text of the guidelines, or request a copy of the short summary trifold "Guide to Dementia Diagnosis & Management in Primary Care" from the CMI Product Line (CMIproducts@kp.org or 510-271-6426).

Also refer to the discussion of dementia guidelines in the Spring 2002 issue of *The Permanente Journal* (Vol 6, No. 2), "Evidence-Based Clinical Vignettes from the Care Management Institute: Alzheimer's Disease and Dementia."

was conducted regarding diagnosis and management of dementia, including evidence on the use of acetylcholinesterase inhibitors. This review resulted in publication of the *CMI Dementia Guidelines*[a] (a technical review of the guideline recommendations and evidence) and of the *CMI Dementia Care Program,*[a] which contains information on key principles of caring for people with dementia and on models for optimal management of these patients.

Kaiser Permanente Aging Network: Leveraging our Integrated Model of Care

In 2000, KP and KFHP leadership developed a proposal to create a jointly sponsored entity, which eventually became known as the Kaiser Permanente Aging Network (KPAN), whose work formally started in January 2001. KPAN's codirectors come from KFHP and from The Permanente Federation and are accountable to the CMI Board. This organizational structure allows easy blending of CMI and IRCOA functions as well as development of new work. KPAN has a leadership team of KP Program and Regional leaders who guide KPAN's work. The KPAN Strategy and Implementation Council, consisting of regional clinical and business stakeholders and leaders, informs and reflects KPAN's work and focuses on operationalizing CMI and KPAN work at a local level.

KPAN's vision is to optimize the health and function of older adult members. Its aim is to leverage KP's integrated model to create, implement, and evaluate effective and efficient clinical and business strategies to realize its vision. KPAN will

- Work to set standards by working with experts and stakeholders;
- Empower local providers to facilitate improvements;
- Inform through development of pilot programs, quality improvement initiatives, and formal research projects;
- Involve all participants by establishing formal groups of business and clinical leaders; and
- Unify all voices by creating a community of stakeholders with common goals and vision.

To support KP regions in their efforts to refine practices and services for older adults, KPAN has been engaged in invitational regional consultations to the KP Northwest, Hawaii, Ohio, Mid-Atlantic, and Colorado Regions. Consultations consist of focused hospital record reviews, meetings with regional business and clinical leaders and managers, review of the organization and accountabilities for Elder Care services, and discussion of best practices and promising models in use at KP. Recently KP regions received a region-specific "Elder Care Profile," which consolidates multiple sources of data on this population. Regions are in different stages of development of their programs, but a common finding in reviews is a pattern in which multiple interventions are aimed at multiple problems of older, chronically ill members but lack an explicit unifying goal. This situation presents a KP Programwide opportunity for improving care of people with advanced illness.

Palliative Care Initiative

To begin to address that opportunity, KPAN has leveraged the CMI work on palliative care and has partnered with the Garfield Memorial Fund to issue the Palliative Care Initiative. This research aims to build and test models of care for members with serious, advanced, life-limiting illness. The initiative is currently supporting

- Development of an Advanced Illness Index to assist in identifying older adults at risk for dying within three years;
- A randomized controlled trial in Hawaii and Denver that will further testing and dissemination of the home-based palliative care program developed in the KP Southern California Region. This program offers hospicelike services to members who are not eligible for hospice care because of the prognosis or because they do not want to give up attempts to modify their disease;
- A randomized controlled trial of inpatient palliative care teams in Portland, Denver, and San Francisco. This program focuses on communication, on symptom management, and on setting patient-centered goals;
- A randomized controlled trial of an office-based intervention that uses a nurse or social

Photo by TL Max McMillen

worker who, upon referral, has six structured visits with patients and surrogate decision makers. These conversations start by focusing on what patients know and fear about their illness, and eventually a plan is developed that reflects preferences for when death seems more imminent. This plan is communicated regularly to the physician who is directing care.

Looking Ahead

Recognizing the size, complexity, and importance of our older adult population today, KP is taking steps to prepare to manage this cohort successfully into the future. One of the first steps is to define successful management of this population, and what structures and systems are required. To that end, KPAN has codified the "core competencies," or goal states, for several key domains, including:

- Organization/Structure
- Integrated Clinical and Business Planning and Decision Making
- Quality/Performance Improvement
- Clinician Attitudes, Knowledge, and Skills
- Member/Caregiver Participation and Activation
- Core Services for the Geriatric Population
- Internal and External Collaboration.

Linked to the KP Promise, each of these domains and the associated core competencies outline key aspects of KP regional operations needed to effectively manage this population. The domains are intended to help KP regions and local areas map out plans for structural growth and develop skills for both the short and long term.

Work toward achieving competency in each of the domains outlined above may seem daunting. But throughout KP, model programs and successful systems and practices already exist and can be further developed and expanded to address additional needs. Building on our strengths (such as coordinating care in skilled nursing facilities (SNF) and providing group appointments) and expanding systems and programs that have demonstrated success (such as a single point of contact and 24-hour/7-day-a-week telephone access for vulnerable populations) will enable us to make steady strides over time. The importance of meaningful, reliable measures to track progress over time will be essential.

Some of our future advances and improvements in caring for older adults will be supported by the automated medical record (AMR) that the KP Program implements. The potential benefits for capturing information and for using medical terminology consistently, for enabling decision-support technology, and for gathering data on the older adult population are enormous. In places where it exists across the continuum of care, the AMR is showing value by supporting continuity of care and goals for older adults who travel between hospital, home health, SNF care, and the ambulatory setting.

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Many physicians and staff at KP touch the lives of our older adult members and their families in some way. Given the nature of this cohort's needs and the demographic realities of an aging population, the combined efforts and collaboration of every one of those physicians and staff will be needed to provide superior care to these members. Many of the baby boomers have relied on KP for their health care needs for decades, and they will expect continued excellent care as their needs change in later life. By tapping into the expertise inside and outside the organization, by building on our strengths and proven successes, and by striving to achieve common core competencies throughout the KP Program, we will be ready for this population. ❖

Wearing Out Life

You always wear out life long before you exhaust the possibilities of living.

— The Bear, William Faulkner, 1987-1962, 1949 Nobel Prize winner