



THE AMERICAN GERIATRICS SOCIETY

EXPANDING MEDICARE SUPPORT FOR CARE COORDINATION: SERVING COMPLEX OLDER ADULTS

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THE COST OF CARING FOR OLDER ADULTS WITH COMPLEX CHRONIC CONDITIONS

Almost 25% of Medicare beneficiaries have four or more chronic conditions – costing six times as much as beneficiaries with 2 chronic conditions and 13 times as much as those with one condition. Several studies have demonstrated that care coordination enhances the health and quality of life of frail elders and that it has potential to reduce the cost of care. For example, the Geriatric Resources for Assessment and Care of Elders (GRACE) program, a team approach to preventive healthcare delivery for older adults, has shown improved health and quality of life, decreased emergency department visits and lowered hospital admission rates.ⁱ Guided Care, another primary care enhancement program aimed at older adults, found that patients in the program, compared to those who received usual care, spent less time in hospitals and skilled nursing facilities and had fewer emergency room visits and home health episodes.ⁱⁱ

Chronic Disease Prevalence, Cost and Physician Use Among Medicare Beneficiaries					
	Number of Chronic Conditions				
	0	1	2	3	4 or more
Percent of all Medicare beneficiaries, 1999	18%	17%	22%	19%	24%
Average Medicare expenditures, 1999	\$211	\$1,154	\$2,394	\$4,701	\$13,973
Percentage that sees more than 10 different physicians per year, 2003	6%	18%	40%	61%	N/A

SOURCE: MedPAC, 2006; Wolf et al., 2002.

80% OF MEDICARE BENEFICIARIES DO NOT HAVE ACCESS TO CARE COORDINATION

Overall, patients with five or more complex chronic conditions account for more than 75% of total Medicare spending.ⁱⁱⁱ Yet, patients under the Medicare Fee for Service Program – which serves 80% of all beneficiaries -- do not have routine access to care coordination services. They do not have access to these services primarily because Medicare does not reimburse for the more in-depth consultations, follow-up meetings and phone calls provided by interprofessional geriatrics team members that are central to care coordination.

ABOUT CARE COORDINATION

Caring for older adults with multiple health problems requires development and implementation of individualized, coordinated plans of care. These plans of care often call for further evaluation, treatment, referrals and patient or caregiver education or both. Typically, a team of geriatrics healthcare providers -- which may include physicians, geriatrics nurses, pharmacists, psychiatrists, therapists and social workers -- is involved and a primary care provider, such as a physician or nurse practitioner, handles care coordination. Coordination usually involves managing care transitions across settings -- including nursing homes, hospitals, rehabilitation centers, home healthcare, and other sites.

THE ROLE OF A COMPREHENSIVE GERIATRIC ASSESSMENT IN CARE COORDINATION AND IN IMPROVING QUALITY

A Geriatric Assessment is a central component of providing the necessary and appropriate care for older adults with complex and multiple health conditions. Geriatric assessment goes beyond the standard adult comprehensive history and physical exam, including evaluations of special significance among older adults.

MOVING TOWARDS A SYSTEM THAT SUPPORTS CARE COORDINATION FOR ALL MEDICARE BENEFICIARIES

AGS supports:

- [Medical Home Model](#) since patient-centered, coordinated care is one of the foundations of effective geriatric medicine.
- In addition, AGS believes that we should look at refining the Medicare payment system to better support well-coordinated team care.

ⁱ Counsell et al., Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention. *Journal of the American Geriatrics Society* (57:1420–1426, 2009)

ⁱⁱ Leff et al., Guided Care and the Cost of Complex Healthcare: A Preliminary Report. *American Journal of Managed Care* (15(8):555-559, 2009)

ⁱⁱⁱ Centers for Disease Prevention and Control. Chronic Diseases Overview (March 20, 2008) <http://www.cdc.gov/nccdphp/overview.htm> (accessed July 23, 2008).