

Frailty and Risk for Medicaid Members

- Rick Glanz, Chief Executive Officer at SeniorMetrix

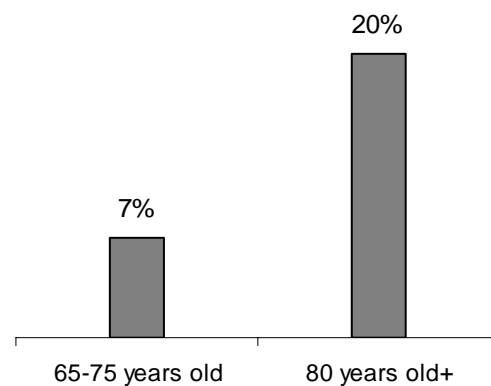
Frail₁

1. **having delicate health; not robust; weak: *My grandfather is rather frail now.***

We all know someone who could be described as frail. It could be the nice neighbor who fell last week or the relative who needs help getting in and out of the car. As a state Medicaid Agency or Health Plan, “frailty” describes those who qualify for long term nursing home coverage under federal definitions. Until recently, researchers didn't have a clear definition of "frailty," a condition that appears to put people at increased risk of developing numerous health problems. Having a clear and reliable definition of frailty is key to conducting usable research in this area, which subsequently is used to identify - and then treat - people who are likely to develop multiple health problems.

Physicians have often used the term "frail" to describe people who were weak or had balance problems, but that definition was vague. **Recently, researchers came up with a new definition that classifies someone as "frail" if he or she has three or more of the following: muscle weakness, slow walking speed, exhaustion, low physical activity levels, or unintentional weight loss.** One recent study, in fact, showed that people who met this description ran an increased risk of becoming disabled. Some additional research has also found that people meeting the description are more likely to fall, to be hospitalized, and to die within several years.²

Prevalence of Frailty, by Age Group



Medicaid managed care plans have more challenges and opportunity than ever before to enhance services and increase shareholder value through better frailty management. Related to this trend, many states already are embarking on initiatives to move people out of nursing homes and into the community. At least 27 states are moving toward “long-term care diversion” projects on their own or in collaboration with private health plans³. To be successful in managing an elderly or disabled population, plans must improve their ability to identify high risk members and manage the risks associated with frailty.

Frailty is highly correlational with age. Researchers estimate that 3 to 7 percent of 65 to 75 year olds are considered “frail” but that increases to 20% for those over 80⁴. In addition and in regard to its personal impact, frailty is also a significant factor in hospitalization, falls, other accidents and nursing home placement. Since life expectancy in the U.S. is currently 78 years, frailty management (for one’s self or a loved one) will undoubtedly be an issue for most Americans at some point.

Care Managers who work with frail or disabled populations realize that diagnostic claims history or standard health risk assessments fall short when trying to identify members’ physical needs and risk factors. Consequently, many governmental, academic and provider-based organizations

have created or adapted measurement indicators to better identify those who need assistance or who are otherwise at risk.

Why versus What

It is very important to distinguish the differences between “why” some people are frail versus “what” is the level of their frailty. People become frail due to injury, disease or factors related to aging. The presence of these factors may indicate the likelihood of diminished functional capacity, but show very little about the degree of loss. A person who is diagnosed with an ICD-9 code of 436 (CVA) could show no lingering effects or they may be totally paralyzed. Therefore, the level of function, the “what”, is much more relevant to caregivers or health plans.

Researchers and physicians may be able to provide many answers about the factors that drive frailty, but how do those responsible for care determine the degree of functional impairment and what specifically to do about it? Health plans typically rely on claims data to target members for disease or care management, but the ICD-9 codes in those records provide almost no insight about those who might be frail. Worse yet, Medicaid plans with dual eligible members usually don't have access to the Medicare claims that contain what little data may exist.

The Power of Measurement

The good news is that an individual's level of function can be measured in reliable and accurate ways. There are dozens of tools that clinicians use to assign an ordinal value to a person's ability to complete every day tasks. Most of these relate to either Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL).

ADL- Tasks of Every Day Life	
Eating	Grooming
Dressing	Using the Bathroom
Walking	Basic communication, memory and problem solving
Bathing	

ADL Checklist:

http://www.pbs.org/wgbh/caringforyourparents/handbook/pdf/cfyp_adl_checklist.pdf

Functional scores, when combined with large databases of actual patient results, are very powerful in predicting recovery after a functional loss and establishing a burden of care (how many hours per day of help someone needs). In addition, functional status can be highly correlated with fall risk. The data suggests that lower functional mobility scores are found in those with higher risk for falls⁵.

IADL-Tasks related to Independent Living	
Preparing Meals	Managing Money
Using a Telephone	Housework
Traveling	Taking Medicine

The benefit of combining functional measurement of an individual with the results of similar patients is that it removes much of the subjectivity of the care management process. As a result, care coordinators can enhance their personal training and experience with impartial

insight about what most likely are the member's needs. This technique has been successfully applied in several states (California, Washington, Tennessee, Maryland, Virginia, Colorado, Arizona) to predict recovery after hospitalization and to manage ongoing benefits such as in-home care giving services. Knowing the functional level and required care giver hours allows you to identify those who have a gap between the amount of care they need and the amount of care

that is actually being received to be safe at home. Such knowledge allows plans to either establish a safe level of support or to place an individual in a more appropriate setting before a crisis necessitates a transition.

Most measurement scales quantify similar types of activity. These measurements give a reliable reading of basic areas of function or provide a score that represents the total individual. Many of these measures break down a person's functional status into: Mobility (lower body); Hygiene (upper body); and Mental Status (memory and problem solving).

Using Functional Measurement

Very few measurement indicators can be compared to (or cross-walked) to one another for comparative purposes. This means that the results in different care settings cannot be compared unless both settings use the same measures.

Most functional scales have limitations or differences in their "floors" and "ceilings" because traditional paper/pencil, static testing, requires hundreds of questions to address the full range of ADL and IADL activities.

Perhaps the biggest limitation with most tools is the requirement that a nurse, therapist or physician must administer them. This can be very burdensome and costly for health plans trying to adequately identify their frail membership.

New technologies give even untrained individuals the ability to generate a functional score. Item Response Theory tools can position an individual on a very wide spectrum of function by asking about 2 dozen questions. A comparable paper and pencil tool would require about 250 questions.

Variation is the Enemy of Quality

Perhaps the biggest enemy of efficiency and cost control in the health care system is unexplained practice variation. In virtually every sector there are glaring examples of excess care being delivered that does not contribute to patient quality or result. In fact there is a great deal of research that suggests that more care/cost may result in worse patient outcomes. ⁶

If organizations have any hope of optimizing their value, they must incorporate new methods to view themselves in objective ways. The accountants who evaluate our success would never be happy with "close is good enough". Why, then, should

health plans be satisfied with managing utilization without objective measures and standards?

High performing plans are the ones that hunger for data about their processes and that are eager to look for new levers to enhance objectivity. They maximize their "value" by optimizing the relationship of quality outcomes at the patient level and the cost of that patient's care. Finally, in the world of frailty management, we can confidently move from the world of "I think" to the world of "I know".

As Medicaid plans take on more and more risk for managing frail populations, they will need to develop a systems approach. It is no longer acceptable to rely on statements like "I know we do a good job because we have good case managers" when defending individual or system wide decisions. When family members or other advocates challenge a plan's judgment about the

authorization of home care services, a system relying on robust and objective criteria will be the only way to support the overall process.

Frailty management can be an overwhelming challenge, but several plans are embracing new technologies and method to reduce practice variation, enhance patient outcomes and objectively define their value to the healthcare community.

¹frail. Dictionary.com. *Dictionary.com Unabridged (v 1.1)*. Random House, Inc.
<http://dictionary.reference.com/browse/frail> (accessed: November 12, 2008).

²Source: "Frailty: Emergence and Consequences in Women Aged 65 and Older in the Women's Health Initiative Observational Study." July 2005 issue of the Journal of the American Geriatrics Society (Volume 53, Issue 8, pages 1321-1330).

³Administration on Aging, http://www.aoa.gov/prof/nursing/nursing_grants.aspx

⁴Frailty in Elderly Can Be Proactively Managed: An Expert Interview with Renee Roberts, MSN, RN, NP-C
<http://www.medscape.com/viewarticle/582349>

⁵ SeniorMetrix

⁶**Geography and the Debate over Medicare Reform**

A reform proposal that addresses some underlying causes of Medicare funding woes: geographic variation and lack of incentive for efficient medical practices.

By John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner
<http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.96v1/DC1>

Rick Glanz, CEO of SeniorMetrix

Rick Glanz has more than 20 years of experience as a skilled nursing home operator at the facility and multi-facility level. As the Chief Executive Officer at SeniorMetrix, Glanz works with the company's development team to establish systems for measuring, managing and calibrating the post-acute care continuum and frailty management.

Glanz has lectured across the country on topics such as Medicare reimbursement, post-acute care utilization and reporting, identification of high-risk members, skilled nursing management, frailty management, and finance. He is often published in skilled nursing facility, Medicare Advantage, and Managed Medicaid periodicals.

SeniorMetrix is the only source for evidence-based data, technology, and experience in frailty management. We provide decision-support that assists health plans in better managing their member's care via the optimal relationship of cost and predicted patient outcome.
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