The Hospital Is No Place for the Elderly

MEDICAL TREATMENT FOR AGING, CHRONICALLY ILL PATIENTS IS COSTLY AND OFTEN INEFFECTIVE. CAN THEY GET BETTER CARE AT HOME?

By Jonathan Rauch

It is 1976. Brad Stuart is in his third year of medical school at Stanford, doing his first clinical rotation. He is told to look at an elderly man with advanced lymphoma. The patient is feeble and near death, his bone marrow eviscerated by cancer. The supervising oncologist has ordered a course of chemotherapy using a very toxic investigational drug. Stuart knows enough to feel certain that the treatment will kill the patient, and he does not believe the patient understands this. Like a buck private challenging a colonel, he appeals the decision, but a panel of doctors declines to intervene. *Well*, Stuart thinks, *if it must be done, I will do it myself*. He mixes the drug and administers it. The patient says, "That hurts!" A few days later, the man's bed is empty. What happened? He bled into his brain and died last night. Stuart leaves the room with his fists clenched.

To this day, he believes he killed the patient. "I walked out of that room and said, 'There has got to be a better way than this,' " he told me recently. "I was appalled by how we care for—or, more accurately, fail to care about—people who are near the end of life. We literally treat them to death."

Here is a puzzling fact: From 1970 until 2009, spending on health care in this country rose by more than 9 percent annually, creating fiscal havoc. But in 2009, 2010, and 2011, health-care spending increased by less than 4 percent a year. What explains the change? The recession surely had something to do with it. But several recent studies have found that the recession is not the whole story. One such study, by the Harvard University economists David Cutler and Nikhil Sahni, estimates that "structural changes" in our health-care system account for more than half of the slowdown.

In a sense, Brad Stuart is one of those changes. He is a leader in a growing movement advocating home-based primary care, which represents a fundamental change in the way we care for people who are chronically very ill. The idea is simple: rather than wait until people get sick and need hospitalization, you build a multidisciplinary team that visits them at home, coordinates health-related services, and tries to nip problems in the bud. For the past 15 years, at Sutter Health, a giant network of hospitals and doctors in Northern California, Stuart has devoted himself to developing home-based care for frail, elderly patients.

For years, many people in medicine have understood that late-life care for the chronically sick is not only expensive but also, much too often, ineffective and inhumane. For years, the system seemed

impervious to change. Recently, however, health-care providers have begun to realize that the status quo is what Stuart calls a "burning platform": a system that is too expensive and inefficient to hold. As a result, new home-based programs are finally reaching the market, such as one launched about five years ago at Sutter, called Advanced Illness Management. "It's much more feasible now to make a program like this work than it was a few years ago," Stuart told me. "There are a lot of new payment schemes in the pipeline that are going to make this kind of program much easier to support."

This is good news. Generalizing from a small sample is always perilous, but if what is happening at Sutter is any indication, a more humane, effective, and affordable health-care system is closer than we think.

The problem that home-based primary care addresses has been well understood for years. Thanks to modern treatment, people commonly live into their 70s and 80s and even 90s, many of them with multiple chronic ailments. A single person might be diagnosed with, say, heart failure, arthritis, edema, obesity, diabetes, hearing or vision loss, dementia, and more. These people aren't on death's doorstep, but neither will they recover. Physically (and sometimes cognitively), they are *frail*. Joanne Lynn, the director of the Altarum Institute's Center for Elder Care and Advanced Illness, says that this "frailty course," a gradual and medically complicated downslide, was once exceptional but is now the likely path for half of today's elders.

Seniors with five or more chronic conditions account for less than a fourth of Medicare's beneficiaries but more than two-thirds of its spending—and they are the fastest-growing segment of the Medicare population. What to do with this burgeoning population of the frail elderly? Right now, when something goes wrong, the standard response is to call 911 or go to the emergency room. That leads to a revolving door of hospitalizations, each of them alarmingly expensive. More than a quarter of Medicare's budget is spent on people in their last year of life, and much of that spending is attributable to hospitalization. "The dramatic increase in costs in the last month of life is largely driven by inpatient hospital stays," Helen Adamopoulos recently reported on MedicareNewsGroup.com. "On average, Medicare spends $20,870 per beneficiary who dies while in the hospital."

Hospitals are fine for people who need acute treatments like heart surgery. But they are very often a terrible place for the frail elderly. "Hospitals are hugely dangerous and inappropriately used," says George Taler, a professor of geriatric medicine at Georgetown University and the director of long-term care at MedStar Washington Hospital Center. "They are a great place to be if you have no choice but to risk your life to get better." For many, the worst place of all is the intensive-care unit, that alien planet where, according to a recent study in the *Journal of the American Medical Association*, 29 percent of Medicare beneficiaries wind up in their last month of life. "The focus appears to be on providing curative care in the acute hospital," an accompanying editorial said, "regardless of the likelihood of benefit or preferences of patients."

Taler can attest to one of the more peculiar elements of this situation, which is that a better model—namely, providing care and support at home—has been known and used for decades. Taler himself pioneered an interdisciplinary house-call model in Baltimore in 1980, and in 1999 he co-founded a home-based primary-care program at Washington Hospital Center that has served almost 3,000 people. In the 1970s, the Veterans Administration (now the Department of Veterans Affairs) began

building a home-based primary-care program, which now operates out of nearly every VA medical center and serves more than 31,000 patients a day. This is not newfangled, untested stuff.

Home-based primary care comes in many varieties, but they share a treatment model and a business model. The treatment model begins from the counterintuitive premise that health care should not always be medical care. "It's not medical treatment, it's helping meet personal goals," Brad Stuart said. "It's about 'Who is this person, and what do they want in their life?' "

In Sutter's Advanced Illness Management program, known as AIM, each patient is assigned to a team of nurses, social workers, physical and occupational therapists, and others. The group works under the direction of a primary-care physician, and meets weekly to discuss patient and family problems—anything from a stroke or depression to an unexplained turn for the worse or an unsafe home.

I sat in on some of these team meetings. A social worker and a nurse talked over a case and decided they needed to make a home visit together; a doctor suggested a medication change; the various members of the group compared notes on one patient's hospitalization while discussing whether another's 911 call might have been averted. Strikingly, patients were presented not as bundles of syndromes—as medical charts—but as having personal goals, such as making a trip or getting back on their feet. The team tries to think about meeting patients' goals rather than performing procedures. An advantage of the multidisciplinary approach is that over time, as clients' conditions change, the group can recalibrate the mix of services and providers, to avoid jarring transitions. "Once in AIM, always in AIM," one coordinator told a patient's family. Over several years, a person might move from independence and occasional social-worker visits to hospice care and finally death, all within AIM, and mostly at home.

One recent morning, while I was waiting at Sutter to accompany a nurse and a social worker on a home visit, the phone rang. It was a panicked caregiver whose charge had rectal bleeding. A case manager alerted the patient's regular nurse so that she could make a visit right away, almost certainly averting a 911 call, and possibly an ambulance/ER/hospitalization ordeal. Later, in Washington, D.C., accompanying George Taler on house calls, I met a 92-year-old man afflicted with hypertension, blindness, gout, and diabetes, who had been in and out of the hospital before entering Washington Hospital Center's home-care program in 2007, and who has not been back since—a fact that pleased him. ("I hate the hospital.") I also met a 75-year-old woman who had recently had a massive stroke; her daughter said Taler's program had averted at least two ambulance calls since then.

Sutter figures that the program, by keeping patients out of the hospital whenever possible, saves Medicare upwards of $2,000 a month on each patient, maybe more. The VA, for its part, says its program reduces hospital days for its patients by more than a third and reduces combined costs to the VA and Medicare by about 13 percent.

But now we come to the business model, which has been problematic. For doctors, nurses, health systems, and insurers, providing in-home service costs money. Medicare pays for hospitalization, but it does not pay for much by way of in-home care, or for social workers, or for time spent coordinating complex cases and traveling to homes and talking with caregivers. Where in-home primary care has existed, it has tended to be a foundation-funded experiment, or a charitable project, or part of a vertically integrated system like the VA, which can capture any savings. The home-care program at

Washington Hospital Center runs at a 30 percent loss. Meanwhile, hospitals lose "heads in beds," and therefore revenue. Medicare—which is to say, taxpayers—may save money, but it has no mechanism either to track savings or to pay providers and insurers for hospitalizations that do not happen.

This is why Brad Stuart was frustrated for so many years. He could see the path forward, and others could see it, but it was blocked. Today, though, he's feeling optimistic. The path is clearing.

The elderly flock to Phoenix, Arizona. Not surprisingly, the city is home to one of the country's biggest nonprofit hospice organizations, Hospice of the Valley. Better than most people in the medical system, hospice providers understand the trouble with hospitals. In the early 2000s, Hospice of the Valley began experimenting with an in-home program designed to bridge the frailty gap—that is, the gap between hospital and hospice. That experiment led to the development of a team-based approach in which nurses, nurse-practitioners, social workers, and sometimes physicians visit clients' homes, provide and coordinate care, and observe people outside the context of the medical system. "That face time is what makes the program work," David Butler, Hospice of the Valley's executive medical director, told me. Butler says that for the 900 people it serves, the program decreases hospitalizations by more than 40 percent, and ER visits by 25 to 30 percent.

Though the program collects whatever payment it can from Medicare and private insurance, it operates at a loss, and is run as a community service and a form of R&D. But things have changed recently. Insurance companies and other providers have begun asking Hospice of the Valley to contract with them to pick up their caseloads of high-cost, chronically ill patients. At the beginning of this year, the program was earning enough in reimbursements to cover one out of seven patients; today the rate is more like one in three. That is still not enough, but when a few more big contracts come through, Butler says, perhaps in a year or 18 months, enough of the patient base will be covered to tip the program into the black.

This would have been impossible a few years ago. Most people saw in-home care as too expensive and logistically complicated even to think about—and in any case, no one would pay for it. So what's happened?

A few things, not least among them the Affordable Care Act. Under the new health-care law, Medicare has begun using its financial clout to penalize hospitals that frequently readmit patients. Suddenly, hospitals are not so eager to see Grandma return for the third, fourth, or fifth time. Obamacare has also earmarked money specifically to test new care models, including home-based primary care. Thanks to a $13 million Medicare innovation grant, for example, Sutter is rolling out Advanced Illness Management to its entire health network, to test whether the program can be scaled up. If the results of such tests are good, that would provide impetus—and of course, the very fact that Medicare is investing in the experiment signals its interest. Perhaps most important, Obamacare is changing the business calculus by creating alternatives to fee-for-service payment. It is beginning to set up new provider networks and payment schemes that let health systems and insurers share in what they can save by preventing unneeded treatment (while also requiring them to shoulder some of the risk of cost overruns).

Those reforms are still fledgling, and too technical to garner public attention amid the ballyhoo over insurance mandates and the like, but they have already begun to reinforce what people in the geriatrics

world tell me is a change in the culture of health care. “The idea of cost avoidance is no longer categorically rejected,” Butler says.

Stuart speaks of a new receptiveness among health systems’ financial executives, at Sutter and elsewhere. “A few years ago, you couldn’t get a new idea across the desk of a CFO unless it generated revenues. If all you could do was save money, it was like, forget it.” Now, he says, CFOs want to hear about savings, because they expect the old sources of revenue—more treatments with more gadgets at higher costs—to dry up. Jeff Burnich, a vice president at Sutter, told me that the business case for AIM is only getting stronger. “Most health providers, if not all of us, lose money on Medicare, so how we make up for that is, we cost-shift to the commercial payers,” he said. But the space for cost-shifting is shrinking. “The way you bend the cost curve now is by focusing on where there’s waste and inefficiency, and that’s the end of life in the Medicare population.” He expects to see a wave of hospitals fail in coming years if they don’t provide better value. “The music has stopped,” he said, “and there are five people standing, and one chair.”

Switching to a home-based model of primary care will be a challenge. Medicare, a bureaucratic behemoth designed in the 1960s, moves slowly and will need a lot of time to adjust. Physicians, a notoriously self-important lot, will need to see themselves as part of a team in which a nurse or a social worker often takes the lead. Nurses will need to see hospitalization as a last rather than a first resort. Patients will need to learn that home care can be as good as hospital care, often better. None of this will happen fast.

Still, the mood among people I’ve talked with in the home-based movement is upbeat. I think of them as mammals skittering beneath the feet of dinosaurs, fragile and vulnerable in a newly established niche but better adapted to the changing ecology. The very fact that change agents like Brad Stuart at Sutter, George Taler at Washington Hospital Center, and David Butler at Hospice of the Valley have found success and built constituencies within big corporate health-care systems speaks volumes. At Sutter, AIM has acquired institutional and financial momentum of its own; executives there say they expect to expand their annual patient load from about 2,000 today to between 5,000 and 7,000, which would make it the Sutter network’s standard method of care for the frail. “We can’t staff up fast enough to meet the demand,” Sutter’s Jeff Burnich said. “It would be easier to close a hospital than to close this program.”

Believing that AIM’s future is secure, Brad Stuart recently left Sutter and, with a colleague, formed a consulting company called Advanced Care Innovation Strategies, to advise health systems and insurance companies around the country on better ways to cope with frail patients and advanced illness. With his 65th birthday coming up, Stuart will soon qualify for Medicare himself. His wife wishes he would slow down, before his own frailty course sets in. He refuses. “That would be like spiritual suicide right now,” he told me, “because there is so much going on. I’m more hopeful all the time. We’ve rolled the rock all the way to the top of the hill, and now we have to run to keep up as it rolls down the other side.”

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