Geriatric Care Becomes More Challenging in the Covid-19 Era

Michael D. Cantor, MD, JD, Chief Medical Officer, Bright Health Plan
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Insufficient care coordination, lack of social support networks, and inadequate access to behavioral health are longstanding challenges for older patients. In the wake of Covid-19, telemedicine can be a partial solution.

What are the top three challenges in providing effective elder care?

- Insufficient care coordination to ensure best outcomes: 66%
- Clinicians lack time required to care for elder patients: 53%
- Lack of community-based support organizations: 38%

Providing quality care to older patients has always been challenging, and the arrival of Covid-19 has increased the difficulty of providing care to meet the needs of seniors. Clinicians and health care systems face new problems, many of which are due to exacerbation of longstanding challenges.

In a survey of NEJM Catalyst Insights Council members in March 2020, two-thirds of respondents say that insufficient care coordination to ensure best outcomes is the leading geriatric care challenge facing providers. The survey was fielded before the impact of Covid-19 on seniors and their health care was widely appreciated by respondents.
Michael Cantor, MD, JD, is Chief Medical Officer at Bright Health Plan and a geriatrician with extensive experience in designing and implementing population health and quality improvement programs for health plans and health care providers. He says that care coordination difficulties with geriatric patients stem from a lack of clarity about who is responsible for nonmedical aspects of care, the sometimes time-consuming nature of working with complex older patients, and the challenges of providing holistic team-based care.

“The issue with care coordination is that providers may not be able to manage both medical and nonmedical issues, such as making sure patients see all their doctors and specialists, and connecting them with community-based support organizations that provide resources to address social determinants of health (SDOH) needs such as food, housing, and transportation. The data from the survey show that many providers recognize the challenges of coordinating care for patients with multiple chronic needs, yet may lack resources to effectively coordinate medical and nonmedical services.”

Looking to the future, Cantor believes that the negative impacts of Covid-19 on older adults will extend beyond the immediate need to diagnose and support patients infected with the virus.

“The issues of transportation, nutrition, housing, financial stability, and medication costs are just going to get worse for older patients. One of the keys to good geriatric care is that it requires using a holistic approach. Although senior care resources were available before Covid-19, those resources may be more difficult to access because of the growing needs of the population as a whole.”

Unfortunately, some of the things that impair the health of geriatric patients are exacerbated by Covid-19. For example, more than half of survey respondents (54%) report that the lack of a social support network is the top challenge facing older patients. The need for social distancing to avoid exposure to the virus is resulting in worsening isolation. Older adults have lost access to senior centers and less formal opportunities for socialization that often provide additional benefits, including exercise and nutrition. These opportunities for socialization will not be coming back anytime soon, Cantor says.

He cites nursing homes as an example of the serious impact of isolation due to Covid-19. “Currently, no family members or friends are allowed to visit nursing homes to reduce the risk of introducing the virus into the facilities. Family and friends often provide hands-on caregiving and act as advocates for the frailest residents. Their absence and the decrease in nursing home staffing due to Covid-19 infection is increasing morbidity and mortality for nursing home residents.”
Many older patients have had challenges accessing behavioral health, and Covid-19 is amplifying this problem as well. Before Covid-19, one of the strategies to improve the availability of behavioral health services was to co-locate them with primary care services. In fact, 42% of Insights Council members say they now use such programs. Unfortunately, Covid-19 has significantly reduced clinic visits for primary care and behavioral health.

Cantor says it is critical for geriatric patients to receive behavioral health services, citing the link with physical health. “The integration of primary care and behavioral health services makes sense for a lot of reasons. Analysis of health care costs demonstrates that patients with a single behavioral health diagnosis have much higher medical costs even after controlling for age, gender, and excluding the cost of behavioral health visits and medications.

“No one knows whether physical illnesses cause behavioral health illnesses or vice versa. Clearly, having both physical and behavioral health diagnoses complicates treatment and necessitates a holistic care plan addressing behavioral and physical health in an integrated way. Additionally, 90% of behavioral health care is provided outside of the behavioral health care system. That means for problems like anxiety and depression, the overwhelming majority of patients are not going to see a psychiatrist or behavioral health provider.”

Frailty screening is a useful way of identifying adults at higher risk of morbidity and mortality, and the survey reveals that frailty screening is common.

One of the more effective solutions to the problem of older patients not being able to make visits to primary care and/or behavioral health offices is the use of telehealth/telemonitoring tools. While only 19% of respondents in our March survey say that their organizations either always or often use these tools, and 70% say that they either rarely or never use such tools, these usage numbers have increased significantly.

“These results will change dramatically, if they haven’t already,” says Cantor. “And all of health care will be impacted going forward, not just geriatric care, in terms of reduction of in-person visits, increased use of remote patient monitoring technology, changes in office space requirements, and the design of medical buildings.”

“Seniors are at high risk for Covid-19, so it isn’t just about combining primary care with behavioral health, or even the benefits of using geriatric specialists versus primary care providers. We need to focus on bringing care to the patient, rather than bringing the patient to the care,” he says.

Among older adults, those who are frail are at significantly higher risk of complications of illness and treatment. Frailty screening is a useful way of identifying adults at higher risk of morbidity and mortality, and the survey reveals that frailty screening is common. More than half (54%) of respondents say their organization either always or often screens patients for frailty.
Cantor stresses that it is critical for older patients to be screened for frailty. “People who are frail are at much higher risk for bad outcomes and complications of medical care, and surgical risks are much greater. For example, if a patient has been assessed for frailty, a surgeon is better able to determine whether it’s safe to operate, how well a patient may tolerate anesthesia, and how to approach postoperative pain management. As elective procedures start up as states relax Covid-19–related restrictions, frailty screening should be part of evaluating the safety and risks of the procedure.”

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Charts and Commentary

We surveyed members of the NEJM Catalyst Insights Council — composed of health care executives, clinical leaders, and clinicians from organizations directly involved in care delivery — about elder care. The survey explores the most effective medical approaches to caring for elder patients, challenges to providing effective elder care, challenges facing elder patients, the priority of elder care at organizations, integration with community-based organizations and post-acute care facilities, the relationship between elder care and behavioral health services, respondents’ organizations’ approach to elder care, the use of telehealth/telemonitoring tools in elder care, frailty screening as part of routine elder health care, and the effectiveness of PACE (Program for All-Inclusive Care for the Elderly) to improve elder care. Completed surveys from 507 respondents are included in the analysis.
Multiple Effective Approaches to Caring for Geriatric Patients

What are the top two most effective medical approaches to caring for elder patients?

- Primary care: 57%
- Geriatric specialists: 54%
- Targeted care management programs: 42%
- Co-management models (e.g., with inpatient medicine teams): 32%

Base: 507 (multiple responses)

A majority of Insights Council members say that primary care and geriatric specialists are the most effective approaches to caring for older patients, although some comment on the benefits of care teams. In a written comment, one clinical leader calls for “Team-based programs that include physicians, behavioral health providers with geriatric expertise, care managers, and visiting nurses. Programs [that] can make home visits when needed, [so that] dual-eligible patients with both Medicare and Medicaid are able to receive needed in-home support on a long-term basis when needed.”

A higher incidence of respondents over 45 years old (59%) than those 45 or younger (45%) say primary care is the most effective approach, and a higher incidence of executives (53%) than clinicians (44%) and clinical leaders (35%) mention targeted care management programs.

“A higher incidence of respondents over 45 years old (59%) than those 45 or younger (45%) say primary care is the most effective approach.”
A majority of survey respondents say the top challenges to effective geriatric care are insufficient care coordination and insufficient clinician time. More executives (46%) and clinical leaders (41%) than clinicians (31%) mention no formal organizational strategy for elder care, and a higher incidence of clinicians (39%) than clinical leaders (32%) and executives (26%) cite lack of clinician training in geriatric care.

Comments one executive, “Traditional Medicare has little coordination, education, or patient centeredness about it. ACO care may be improving that, but very, very slowly.”
A majority of survey respondents say lack of social supports is the top challenge facing older patients. One clinical leader says, “80% of health is determined by social factors, and 80% of senior hospitalization is due to the social component, yet we try to apply a medical model to social issues. When we address the social [needs], medical needs go way down and those that exist are way easier to manage.”
Fully 70% of Insights Council members say that geriatric care is an extremely significant, very significant, or significant priority at their organization. One clinical leader turns to an Institute for Healthcare Improvement framework for prioritization. “The IHI Age-Friendly Health System program focuses on what matters most to the older people, and developing care plans around those priorities using the 4-Ms: what Matters most, Medications, Mentation, and Mobility.”

A higher incidence of executives (53%) than clinical leaders (35%) and clinicians (36%) say elder care is an extremely or very significant priority at their organization. However, more clinicians (35%) and clinical leaders (31%) than executives (22%) say that elder care is not very or not at all a significant priority.

“The IHI Age-Friendly Health System program focuses on what matters most to the older people, and developing care plans around those priorities using the 4-Ms: what Matters most, Medications, Mentation, and Mobility.”
Varying Degrees of Integration for Geriatric Care

How integrated is your organization’s approach with community-based organizations and post–acute care facilities in providing care for elder patients?

Survey respondents report moderate levels of integration with community-based organizations and post–acute care facilities, which is consistent with earlier responses regarding the challenge of insufficient care coordination in geriatric care. One clinical leader says, “We are in the midst of working toward seamless integration of community-based elder services (multiple: parish nursing, VNAs, EMTs) with post-acute care of the most medically frail patients. Only by integration of the services will we hope to maintain quality care and affordability.”

Fewer clinicians (19%) say that their organization’s approach is extremely or very integrated with post-acute care facilities, compared with executives (35%).
Varying Degrees of Integration for Geriatric Care Care and Behavioral Health Services

Does your organization’s approach to elder care include services for behavioral health issues (e.g., depression, dementia) that are either bundled with primary care or co-located in the same facility?

No 41%

Yes 42%

Don’t know 16%

Base: 507

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A higher incidence of respondents from nonprofit (45%) than for-profit (34%) organizations say that their organizations offer behavioral health services for older patients.

In written comments, many respondents mention PACE (Program for All-Inclusive Care for the Elderly) as an appropriate place to receive team-based care that includes behavioral health services. “Comprehensive elder care by a combination of primary care, geriatric, and behavioral health providers is provided, along with PT/OT. Takes a holistic approach to keeping elders functional and well managed for their comorbidities,” says a clinical leader.

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Geriatric care becomes more challenging in the COVID-19 era

Palliative care, advanced care planning, and end-of-life care are incorporated in geriatric care at a solid majority of respondents’ organizations. One clinical leader says of advance care planning, “This discussion with patients and their families is important so they can understand where they are in the disease process, and have an appropriate discussion and identify their goals.”

Varying Degrees of Integration for Geriatric Care

Which of the following elements are incorporated in your organization’s approach to elder care?

- Palliative care: 69%
- Advanced care planning: 69%
- End-of-life care: 63%
- None of the above: 14%

Base: 507 (multiple responses)
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“It is critical that the elderly be kept out of the hospital whenever possible because of the dangers of delirium and nosocomial infections. A robust telehealth-supported home care system has the potential to save money and improve the quality of life.”
GERIATRIC CARE BECOMES MORE CHALLENGING IN THE COVID-19 ERA

Little Use of Telehealth/Telemonitoring in Geriatric Care
How often does your organization use telehealth/telemonitoring tools to help manage care for elder patients?

| Always | Often | Rarely | Do not use telehealth/telemonitoring tools | Don’t know |
|--------|-------|--------|------------------------------------------|-----------|
| 1%     | 18%   | 40%    | 30%                                      | 11%       |

Base: 507
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A higher incidence of respondents from for-profit (37%) than nonprofit (27%) organizations say they do not use telehealth/telemonitoring tools for geriatric care, although usage has likely changed as a result of the Covid-19 pandemic. One clinical leader says, “It is critical that the elderly be kept out of the hospital whenever possible because of the dangers of delirium and nosocomial infections. A robust telehealth-supported home care system has the potential to save money and improve the quality of life.”

Frailty Screening Is Common
How often does your organization routinely screen older patients for frailty as part of determining their care needs?

| Always | Often | Rarely | Do not screen for frailty |
|--------|-------|--------|--------------------------|
| 15%    | 39%   | 25%    | 10%                      |

Base: 507
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Frailty screening is a routine part of geriatric health care for a majority of respondents’ organizations. Some respondents mention the benefits of the federal STEADI (Stopping Elderly Accidents, Deaths, and Injuries) program. “Falls in [the] elderly contribute significantly to mortality and morbidity. The program helps sensitize the elderly and caregivers to be mindful about balance, reducing frailty, improving nutrition, and increasing focus on gait training,” says one clinician.
Those Aware of PACE Consider It Effective for Geriatric Care

How effective is the federal Program for All-Inclusive Care for the Elderly (PACE) in improving elder care?

Two-thirds of those aware of PACE indicate that it is effective in improving geriatric care.

Two-thirds of respondents who know about PACE say that it is effective. Says one clinician, “compared to other Medicare/Medicaid programs, PACE participants have fewer total hospital admissions, fewer readmissions, and shorter hospitalizations.”

A higher incidence of executives (20%) than clinical leaders (12%) and clinicians (9%) say that the PACE program is either extremely or very effective in improving elder care. And a higher incidence of clinicians (57%) than clinical leaders (47%) and executives (38%) say that they do not know whether the PACE program is effective in improving elder care.
Verbatim Comments from Survey Respondents

What is the most effective program or initiative for elder care that you know of? Why?

A strong family. Generally what government program aside from Dept. of Defense are effective? Efficient?

— Clinician at a large nonprofit health system in the Midwest

A boutique-like practice. Because the practitioner has more time and a measured schedule.

— Department chair at a small nonprofit teaching hospital in the West

Care coordinators for chronic care. At least chronic illnesses followed and appoints made quickly after hospital discharge.

— Vice President at a midsized nonprofit community hospital in the South

Adult day care. Respite care for family care providers. Keeping able family members involved in elder care is optimal. And keeping family caregivers from getting burned out requires taking care responsibilities out of their hands from time to time. Adult day care offers the caregiver freedom during the day during the week, so they can concentrate their care duties to mornings and evenings.

— Clinician at a nonprofit teaching hospital in the Northeast

At-Home Care program. Integrates home visits with AP and physician, including telehealth. Also, a program of embedded APs in a collaborative fashion with local SNFs has been very effective. Brings care directly to the patient. Limitation is that is only available to patients with the organization’s MCO.

— Service line chief at a large nonprofit health system in the Northeast

Community-based programs which vary by state and Medicaid/MediCal resources. These programs can provide daily nursing assessments, medication management, BP and BS monitoring, social/emotional support and meals. Typically the very poor and the wealthy receive the most services. Adult day programs and adult community programs improve the quality of life – both physically and socially.

— Vice President at a small nonprofit long-term care facility in the West

Don’t know of any. None available in my community.

— Clinician at a nonprofit teaching hospital in the South.
Geriatric care becomes more challenging in the COVID-19 era.

Hospital Elder Life Program (HELP) to reduce the incidence of inpatient delirium. Demonstrated success in terms of clinical, financial, and patient satisfaction outcomes, and success in dissemination.

— Department chair at a large nonprofit teaching hospital in the Northeast

Elder justice initiative. Protecting elders from abuse and being targeted by scams.

— Director at a health system in the Midwest

Geriatric Nurse Practitioner working with a Geriatrician MD working with community-based organizations. These people know about the needs of elderly people and the science of care. Doctors and nurses have to be embedded into the community to provide all the supportive services.

— Clinician at a midsized for-profit community hospital in the Northeast

Support programs involving groups with clinical support from mid-level practitioners preferably in same age range. Allows a non-threatening forum for communication with a fearful population.

— Service department chief at a small nonprofit teaching hospital in the Northeast

Integrating home health care with ambulatory care centers plus select post-acute care centers/rehab hospitals. Most medical and social issues arise post-acute care or at transition of care. Most elderly patients still do not get proper, safe, timely, medication reconciliation post-acute care. Most do not get timely follow-up in ambulatory care centers. Specialty care follow-ups from specialists that saw patients in the acute care setting is almost never accomplished in a timely manner. Caregivers struggle with medication management issues, transportation issues, and nutrition-related issues. Home health care staff.

— Vice President at a for-profit clinic in the South

Look to Sweden, Norway, Denmark for the most effective elderly care programs. Their versions of socialized medicine.

— Clinical leader at a large nonprofit health plan in the West

PACE. Comprehensive physical, behavioral, and social care.

— Chief Medical Officer at a small nonprofit health plan in the West
Meals on Wheels addresses SDOH and potential loneliness. I’m not familiar with many elder care programs, although I’ve seen great results from Medicare post-operative rehabilitation. Unfortunately, 21 days of care is not the right amount of care for everyone, especially in cases of multiple health issues (common with the elderly) and repeat infections that may slow down progress. Having worked in long-term care over 20 years ago, some aspects of long-term care have gotten better and others not so much. Adult Day Care options serve a purpose, but I’m not wild about them. Respect and dignity to honor the lives of elders is easily lost in the day-to-day inertia of caring for their needs.

— Executive at a small nonprofit clinic in the Midwest

What is the least effective program or initiative for elder care that you know of? Why?

Usual primary care. Primary care has been decimated by demands to see large numbers of patients very quickly. It’s a tragedy and travesty that physicians have been stripped of the ability to take the time needed to help vulnerable older adult patients.

— Clinician at a large medical school program in the South

PACE is not effective. Very few who would benefit are eligible financially.

— Chief Medical Officer at a midsized nonprofit community hospital in the Northeast

Usual primary care model for those who have advanced infirmity. Need to provide care in the right setting, be it home or a facility. Today’s primary care seldom accomplishes that unless integrated with a program like the above. Keep the elderly out of the ED with the right programs.

— Executive at a large nonprofit health system in the West

The fragmented fee-for-service program we have now. Care is disorganized and not patient-centered.

— Clinician at a small nonprofit teaching hospital in the West

Hospital discharge without coordinated primary care follow-up. Seniors often don’t get the prescriptions, O2, durable medical equipment, etc. on discharge that the inpatient providers planned.

— Department chair at a large nonprofit teaching hospital in the South
Programs for elder patients with dementia and behavioral disturbances. Varying laws and regulations across the country limit this population’s ability to receive the behavioral health services and programming they require for improved quality of life. There is also a national shortage of psychiatrists that lends this to be an even larger issue.

— Executive at a large nonprofit community hospital in the Northeast

Isolating them in institutions with a medical character such as nursing homes. Converts people into med administration/physical therapy problems. Leaves them depressed and lonely for the most part.

— Clinician at a small nonprofit community hospital in the West

Of which community isn’t aware and can’t use. Those that exclude family and caregivers. I think health care should build on models that have been successful, including taking a look at what Alzheimer’s org has been able to do for folks w/dementia and their families/friends/HCPs AND lawyers!!!! That’s a lot of integrating! They keep folks UTD w/latest and offer local where the people live help as well. Until we integrate w/the resources the community is already using, we won’t be as effective (as one facet of working with the older population IMHO).

— Service chief at a small nonprofit health system in the South

Gerontology professionals. The specialist idea is wonderful, but I have yet to have a family member receive care from one that was truly beneficial. My experience is many lack the knowledge of common medication interactions/side effects, seem siloed from the specialists (within their own medical system) they may need to coordinate for care, and although patient-centered, they do not always value the caregiver’s input toward patient abilities and challenges.

— Executive at a small nonprofit clinic in the Midwest

The present system in the United States. One needs huge financial resources or a huge family with some members who don’t work in order to provide adequate 24-hour care. Cost of elder care. Most Americans can’t afford $4800 - $8000/month for care. Medicare basically doesn’t provide long term care.

— Clinician at a large nonprofit health plan in the West

Nursing homes. Devoid of personalized values and cultures. Detachment. Underfunded. Feels like abandonment in some cases.

— Chief Medical Officer at a large nonprofit health system in the West
No program, which is what the majority of average/middle-class people receive. Sometimes the health care plans will have an RN make a follow-up call – while a little helpful that has very limited benefits. An occasional home visit is not sufficient. Ongoing, supportive care, even a few hours every week would make a tremendous difference. Older adults need more support; if they receive the needed support they will not only be happier and healthier but most likely their health care needs and cost will be lower.

— Vice President at a small nonprofit long-term care facility in the West

The subtle but pervasive prejudice among clinicians that old age is synonymous with being on death’s door. Too many clinicians, caught in a medical system that places efficiency of time over effectiveness of diagnosis and diagnostically driven treatment, move on to other things rather than address the full medical needs of the elderly.

— Clinician at a nonprofit research facility in the Northeast

Medicalizing normal aging. People don’t want to buy medical care all the time. Many issues require a social response.

— Manager at a midsized nonprofit health system in the Midwest

Nursing facilities, SNFs. After often 55-60 or more years living on their own to now being in someone else’s house, don’t understand the rules, nothing is yours, no personalization, very sterile surroundings does not stimulate brain awareness or cognitive functioning.

— Director at a small nonprofit health plan in the South
Methodology

- The *Elder Care* survey was conducted by NEJM Catalyst, powered by the NEJM Catalyst Insights Council.

- The NEJM Catalyst Insights Council is a qualified group of U.S. executives, clinical leaders, and clinicians at organizations directly involved in health care delivery, who bring an expert perspective and set of experiences to the conversation about health care transformation. They are change agents who are both influential and knowledgeable.

- In March 2020, an online survey was sent to the NEJM Catalyst Insights Council.

- A total of 507 completed surveys are included in the analysis. The margin of error for a base of 507 is +/- 4.4% at the 95% confidence interval.

NEJM Catalyst Insights Council

We’d like to acknowledge the NEJM Catalyst Insights Council. Insights Council members participate in monthly surveys with specific topics on health care delivery. These results are published as NEJM Catalyst Insights Reports, such as this one, including summary findings, key takeaways from NEJM Catalyst leaders, expert analysis, and commentary.

It is through the Insights Council’s participation and commitment to the transformation of health care delivery that we are able to provide actionable data that can help move the industry forward. To join your peers in the conversation, visit https://catalyst.nejm.org/insights-council.
## Respondent Profile

### Audience Segment
- Executive: 26%
- Clinical Leader: 26%
- Clinician: 48%

### Organization Setting
- Hospital: 39%
- Health system: 16%
- Clinic: 11%
- Physician Organization: 9%
- Other: 26%

### Type of Organization
- Nonprofit: 73%
- For profit: 27%

### Number of Beds (Among hospitals)
- 1 - 50: 9%
- 51 - 199: 13%
- 200 - 499: 29%
- 500 - 999: 29%
- 1000+: 20%

### Number of Sites (Among health systems)
- 1 - 5: 19%
- 6 - 20: 23%
- 21 - 49: 19%
- 50+: 38%

### Number of Physicians (Among physician organizations)
- 1 - 9: 14%
- 10 - 49: 17%
- 50 - 99: 13%
- 100+: 56%

### Net Patient Revenue
- > $5 billion: 18%
- $1 - $4.9 billion: 21%
- $500 - $999.9 million: 9%
- $100 - $499.9 million: 16%
- $10 - $99.9 million: 20%
- < $9.9 million: 17%

### Region
- West: 22%
- Midwest: 20%
- South: 31%
- Northeast: 27%

Base = 507
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About Us

NEJM Catalyst brings health care executives, clinical leaders, and clinicians together to share innovative ideas and practical applications for enhancing the value of health care delivery. From a network of experts and advisors, our digital peer-reviewed journal, live-streamed events, and qualified Insights Council provide real-life examples and actionable solutions to help organizations address urgent challenges affecting health care.

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