Local Community Roles in Long Term Care

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SYSTEMS RESEARCH FOR BETTER HEALTH

Multiple Groups Need Long-term Care

▲ Developmental disability

▲ Serious mental illness and substance abuse

▲ Serious physical disability, not aged

▲ Cognitive failure

▲ Frailty associated with aging

Imagining Frailty

Photo credit: http://www.telegraph.co.uk/health/elderhealth/8917142/David-Cameron-under-pressure-over-care-reforms.html

# Salient Facts about Frail Older People

▲ Tied to their residence

▲ Numbers will more than double within 20 years

▲ Counting long-term care costs, frailty in old age uses around half of a person's lifetime health care costs

▲ Very few have savings or insurance to cover those costs

▲ Therefore, long-term care requires societal investments

▲ Current practices incur unnecessary fear and suffering

▲ Policy is distorted by inability to acknowledge death

U.S. consumption (private plus public in-kind transfers), (1 = average labor income, ages 30-49).
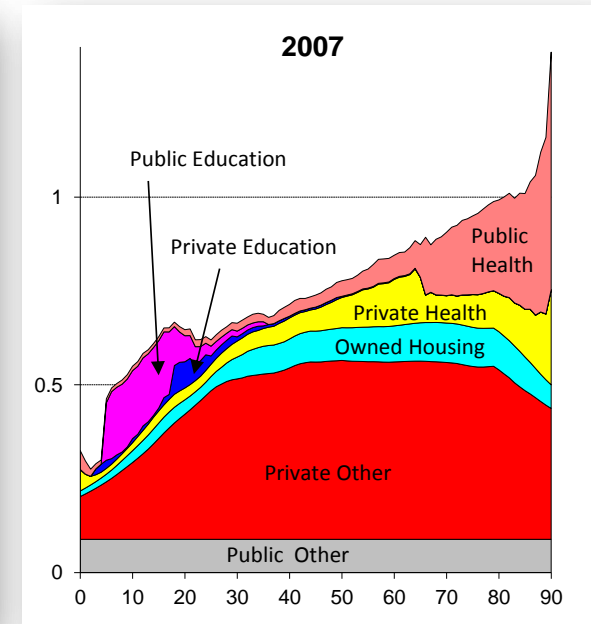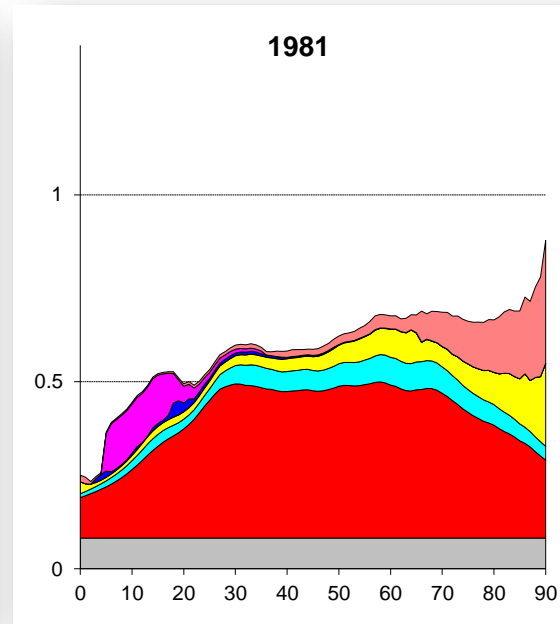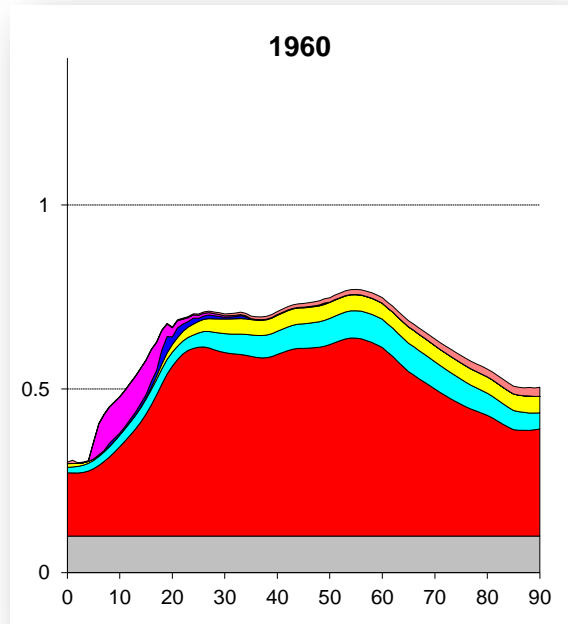
Source: U.S. National Transfer Accounts, Lee and Donehower, 2011.
Also in Aging and the Macroeconomy, National Academy of Sciences, 2013

Why Develop Some Local Management of Services for Frail Elderly Persons?

1. Local entities could integrate social supports and health care

2. Local entities could monitor and manage some issues better than state/federal

3. Having a local role is politically plausible

Primary Drivers

Secondary Drivers

Aim

Frail older adults with complex needs will live with the dignity and independence they want to have, with health care needs met reliably and well, and with a sense of well-being and inclusion in personal relationships and in the community – and with the costs being sustainable for families and for the larger society.

Identify the frail elder population
- Assess risk for illness, disability and death for individuals and populations
- Develop administratively feasible criteria
- Use opt-in or opt-out: Individual/family agreement to use special frailty care

Establish person's current situation and likely course with various care plans
- Understand the affected person and his/her priorities at this stage of life (multi-dimensional assessment)
- Understand family and caregiver(s) capabilities and willingness
- Outline options and predict likely future courses

Develop and implement the care plan (perhaps, "Personal health and well-being plan")
- Develop a shared understanding of what is the most desirable service plan
- Implement the plan, monitor and adapt
- Evaluate the care plan against preferences and values, not just against professional standards
- Routinely evaluate care plans and learn from the evaluation

Make services appropriate for frail elders (including health care, housing, personal care, nutrition, and other supportive services)
- Provide comprehensive support at home
- Follow geriatric/palliative principles and priorities
- Enable promise-making and reliability
- Support caregivers and relationships
- Organize volunteers: family, friends and neighbors

Manage a trustworthy, effective, responsive local service production system with a competent, thriving workforce
- Provide information system to monitor supply, practices, and quality
- Enable governance of the local care system in the interest of frail elders
- Develop appropriate numbers and skills of workforce; reasonable rewards and career ladders
- Reflect appropriate priorities: Reliability, continuity, endurance, dignity

IHI Triple Aim in a Region, 2013

Driver 5: Production System

Manage a trustworthy, effective, responsive local service production system with a competent, thriving workforce

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IHI, Triple Aim in a Region, 2013

What will a local manager need?

▲ Tools for monitoring – data, metrics

▲ Skills in coalition-building and governance

▲ Visibility, value to local residents

▲ Funding – perhaps shared savings

▲ Some authority to speak out, cajole, create incentives and costs of various sorts

▲ A commitment to efficiency as well as quality

CINCINNATI TRANSITIONS: 10 OR MORE
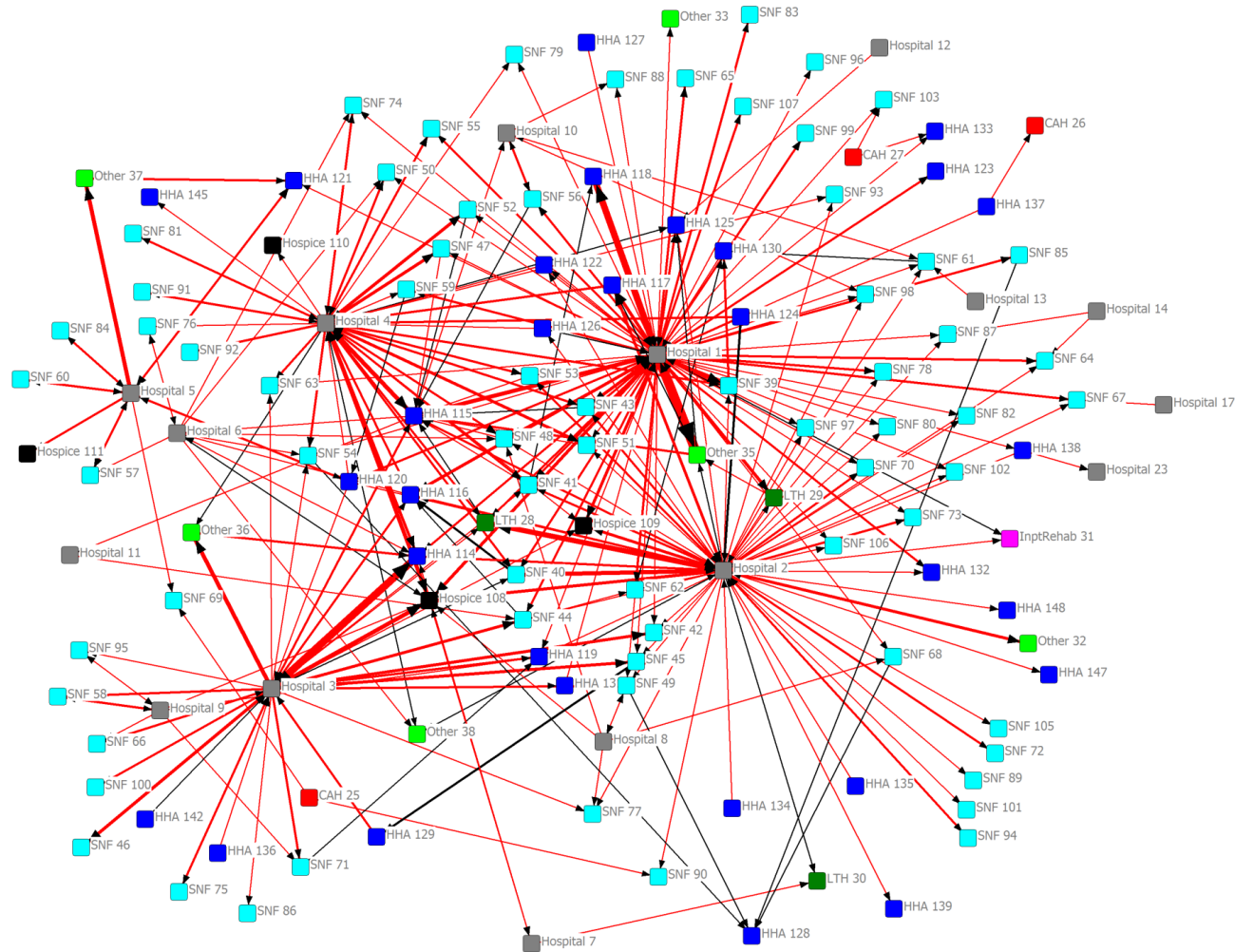
CINCINNATI AREA READMISSIONS OVER TIME
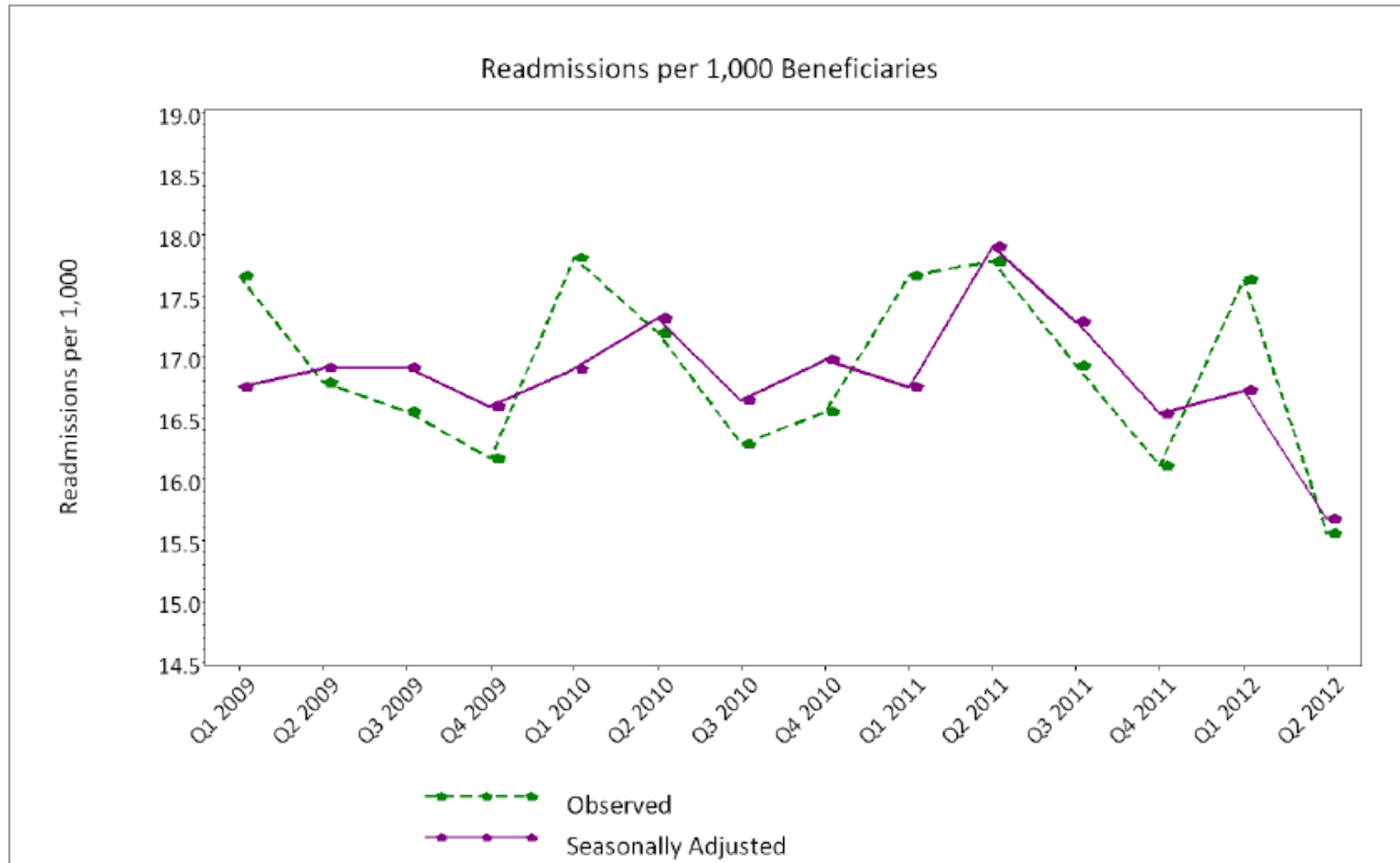
Encourage Geographic Concentration?

YES!

▲ Services to homes will be more efficient if allowed to be geographically concentrated

▲ Can utilize local strengths, solve local issues

▲ However - Must address risks of monopolies

Disaster for the Frail Elderly: A Root Cause

Social Services
- Funded as safety net
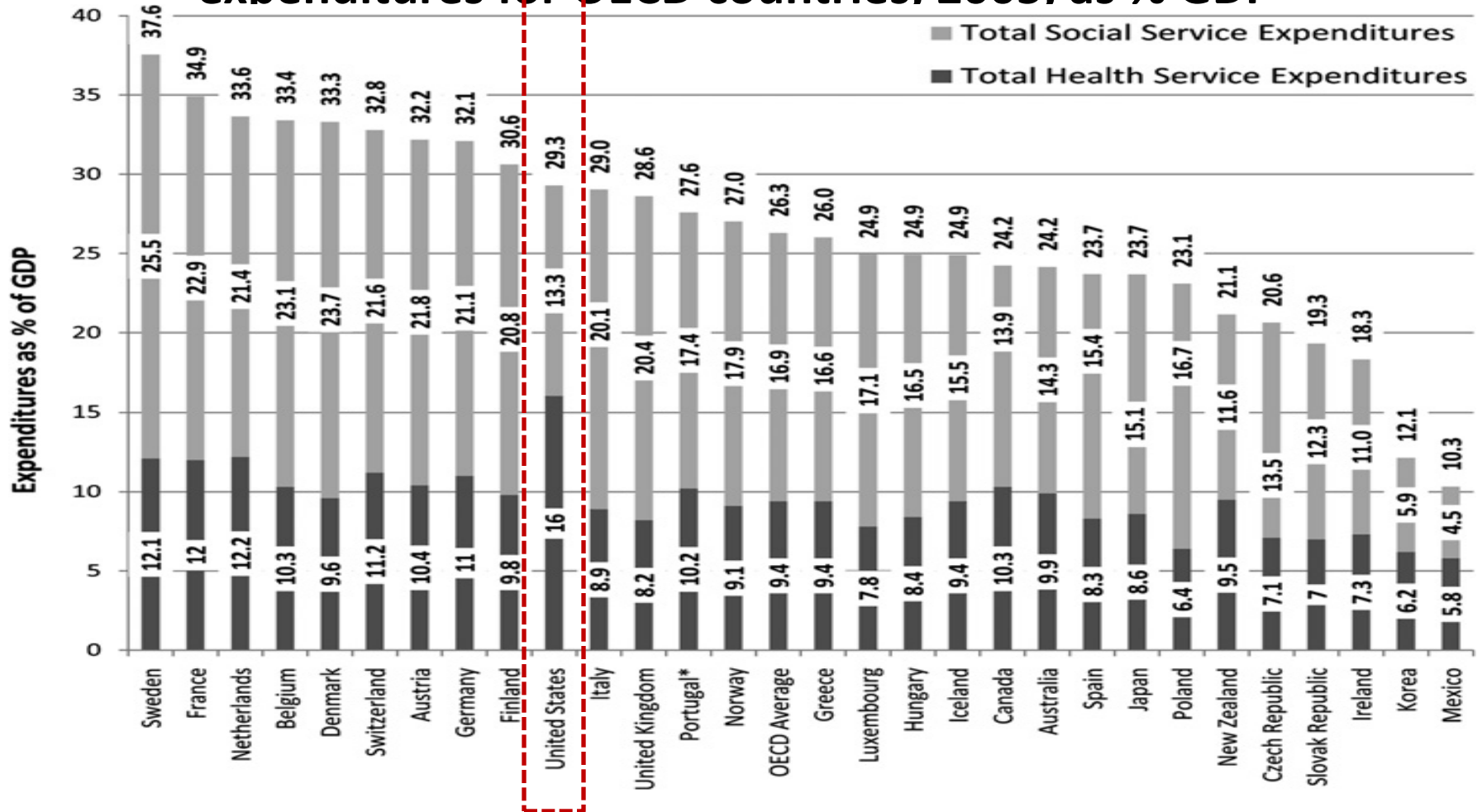- Under-measured
- Many programs, many gaps

Medical Services
- Open-ended funding
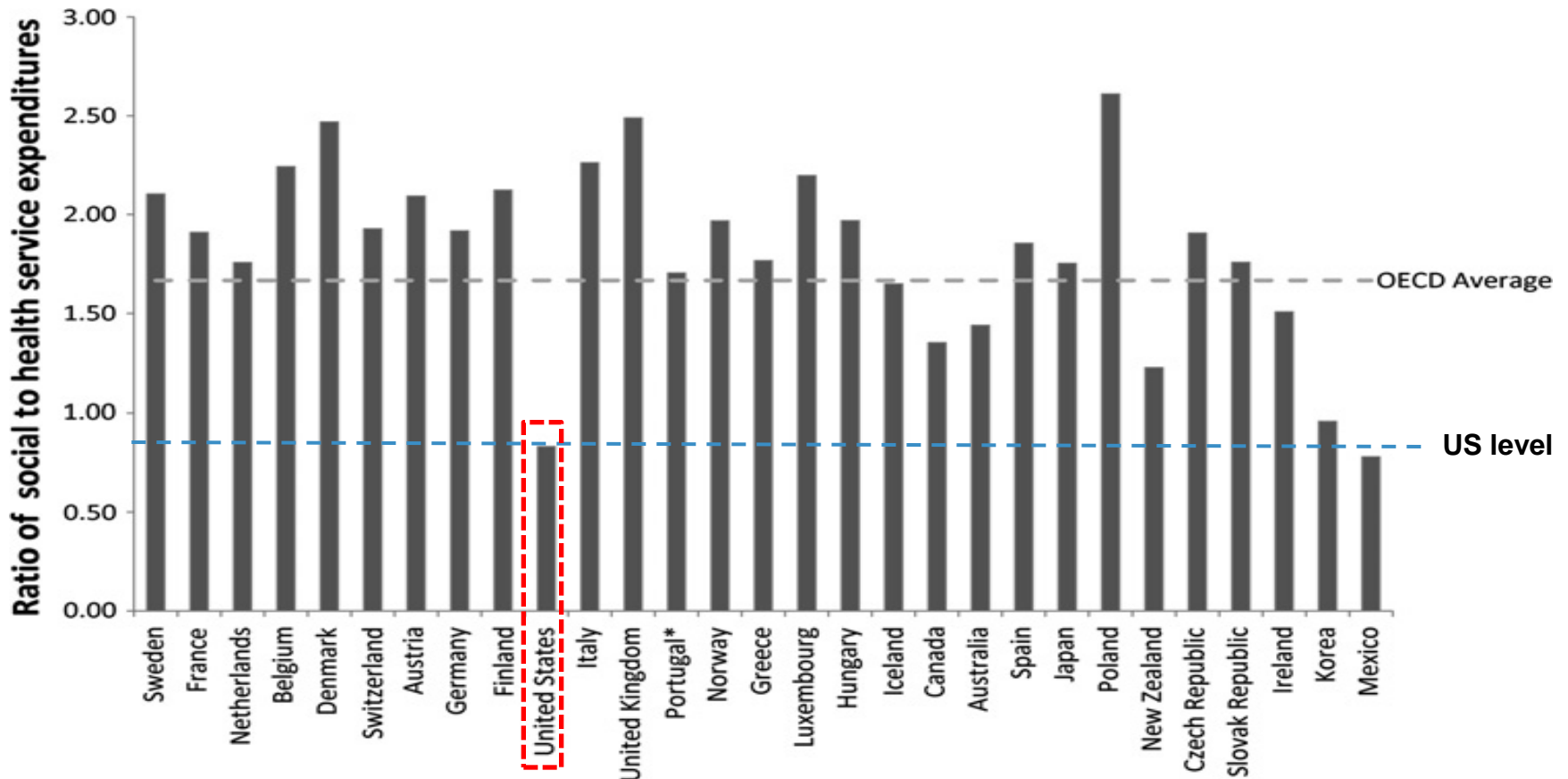- Inappropriate "standard" goals
- Dysfunctional quality measures

No Integrator

Inappropriate

Unreliable

Unmanaged

Wasteful "care"

Scope of "Health" --Health-service and social-services expenditures for OECD countries, 2005, as % GDP

Scope of "Health" -- Health-service and social-services expenditures for OECD countries, 2005, as ratio

BMJ Qual Saf 2011;20:826e831.

An Ideal Service Production System

▲ What inputs would you need to optimize service production?

▲ What follows is conjectural and does not reflect an actual system. It also does not yet include many important elements

▲ *With good care plans for a population, one could model the production system.*

1ˢᵗ Estimate Optimal Production System – N Frail Elderly

▲ For a community with population of 600,000, about 6000/yr will die,

▲ About 5000 while older than 65yo, and

▲ About half with frailty (rather than a single overwhelming disease, at a somewhat younger age)

▲ That group will have self-care disability for about 2 yrs

▲ So, about 5000 elderly people will need supportive services at any one time

▲ What will the community need to provide?

Estimating Optimal Production System - Summary

▲ For total population = 600,000; frail elders = 5000

▲ Home care by family = 2500

▲ Nursing home care = 1000

▲ Direct Care workers = 500 in nursing homes, 1500 home care

▲ Home care nurses = 500

▲ Nursing home nurses = 100

▲ Nursing home and home care therapists = 100 in NH, 100 home care

▲ Hospital beds = 300

▲ 15 FTE primary care physicians

▲ Medical assistants for home care physicians - 10

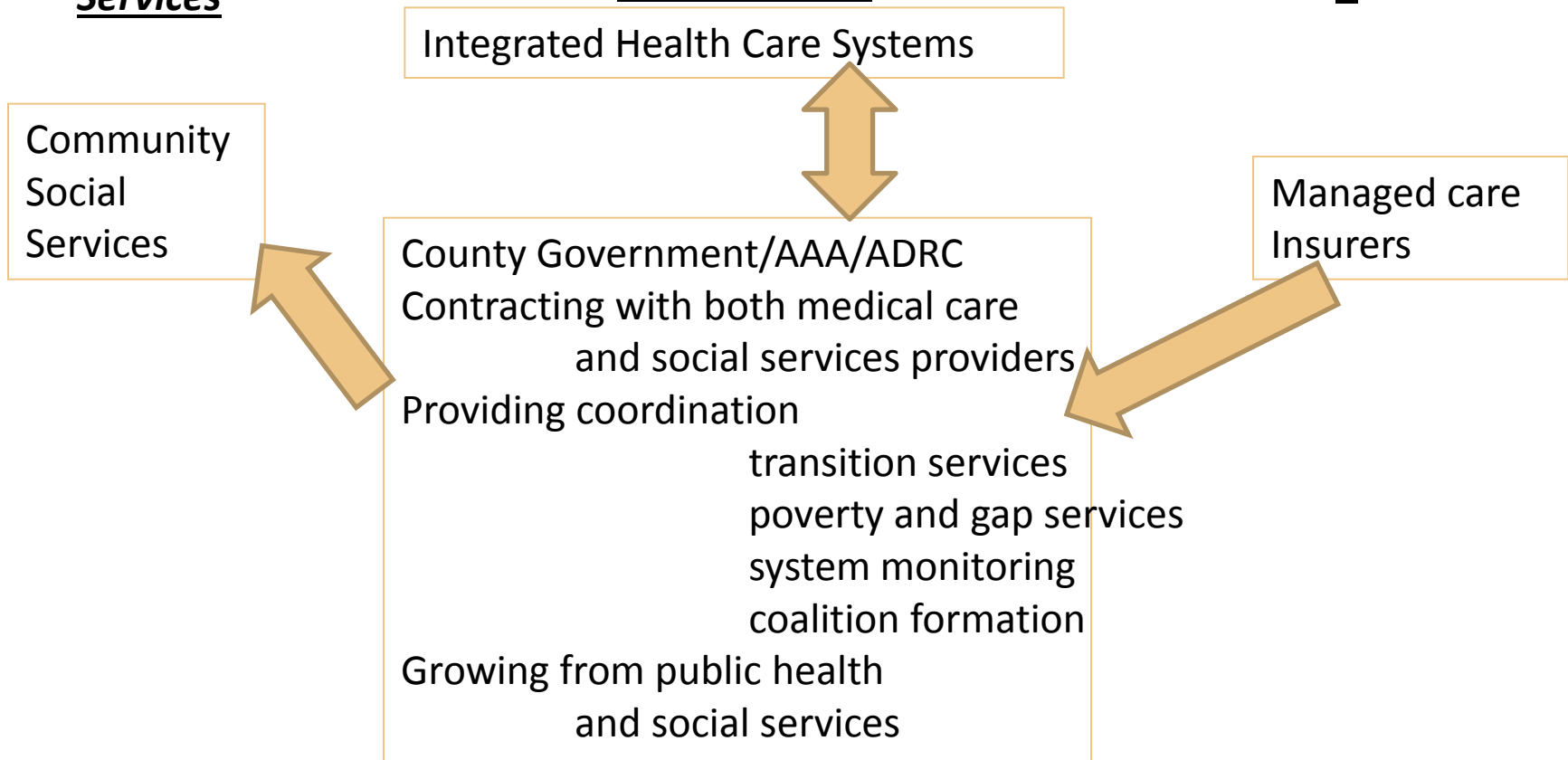# SteppingStones to Local Monitor/Manager – Interim Models in place

1. A voluntary coalition of health care and social service providers, with consensus governance

2. A regional direct service Medicare provider contracting with at-risk payers

3. A regional direct social services provider contracting with at-risk payer

4. A voluntary coalition of health care and social service providers convened by government and organized in part as contractor with at-risk payers

SteppingStones – Interim Model #4 – County Social services Provider

Services　　　　　　　　*Services and $*　　　　　　　　　*$*

Integrated Health Care Systems

Community Social Services

Managed care Insurers

County Government/AAA/ADRC
Contracting with both medical care
　　　　and social services providers
Providing coordination
　　　　　　　　transition services
　　　　　　　　poverty and gap services
　　　　　　　　system monitoring
　　　　　　　　coalition formation
Growing from public health
　　　　and social services

Useful resources

For Data

▲ www.communitydatapalooza.org (check out Cincinnati)

▲ Your QIO – (ask for help with "care transitions")

▲ http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/

For community organizing

http://www.cfmc.org/integratingcare/learning_sessions.htm

For workforce in elder care - http://www.eldercareworkforce.org/

"Somebody has to do something, and it's just incredibly pathetic that it has to be us."

-- Jerry Garcia