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The Integration of the Long Term Care Continuum Into a Seamless Health Delivery System

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THE INTEGRATION OF THE LONG TERM CARE CONTINUUM
INTO A SEAMLESS HEALTH DELIVERY SYSTEM

VIRGINIA E. MOSELEY, B.S.N.

An Abstract Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fulfillment of the
Requirements for the Degree of
Master of Art

1997

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Abstract

A seamless continuum of healthcare services is necessary to serve older adults, caregivers and the community. Personal knowledge and experience of the author, a nurse and skilled nursing facility administrator, is combined with a literature review to determine a vision for serving older adults and caregivers. A vertical integration of long term care into a health delivery network traditionally focused on acute and primary care is proposed.

THE INTEGRATION OF THE LONG TERM CARE CONTINUUM INTO A SEAMLESS HEALTH DELIVERY SYSTEM.

VIRGINIA E. MOSELEY, B.S.N.

A Culminating Project Presented to the Faculty of the
Graduate School of Lindenwood College in Partial
Fulfillment of the Requirements for the Degree of
Master of Art

1997

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DEDICATION

This thesis is dedicated to the frail elderly, their families, and to the compassionate mission-inspired interdisciplinary team of clinicians and staff who devote love, attention, talent, and skills to the geriatric patients whom they so obviously cherish and admire.

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Chapter I

Introduction

The growth of the over 65 population will place a strain on financial programs, health care providers, caregivers, and the business community. As our society experiences the surge in the older population, reimbursement dollars for providers shrink. Health care for the older adult will be impacted by the managed care market. Families will be challenged by the responsibility of caregiving. Business will be negatively impacted as caregivers become less productive on the job. Health systems with a vision for combining long term care services within the acute and primary care industry can enhance revenues while meeting the needs of older adults, caregivers, and business .

The elderly, who comprise the sickest segment of our society experience negative outcomes in the health delivery system of today. Mismanagement of chronic health care needs, fragmented services, misuse of medications with minimal pharmacy coordination, inadequate care management, limited health education/patient teaching, and caregiver stress lead to hospitalization or institutionalization with a subsequent downward spiraling effect on the health of the older adult.

As our society ages and the demands for informal and formal health care increase, the acute health care networks will be called upon to address the chronic and holistic needs of the older adult and caregiver. A full continuum of primary, acute

and long term services integrated into the health systems is a necessity in order to meet the needs of the senior and caregiver, and survive the cost of assuring quality care in an effecient manner.

This thesis describes the burgeoning demographics of our aging society, health care problems and needs of the older adult, caregiver support, reimbursement issues as managed care impacts the long term care industry, and benefit of including a full spectrum of senior services in seamless continuum of health delivery. Methods for assessing needs, community resources, and partnerships are addressed. A vision for vertically integrating long term care into a delivery network traditionally concerned with acute and primary care is proposed.

Chapter II

Literature Review

An Aging Society

The population of older adults will surge by 2020 as baby boomers head into old age. El Nasser and Stone (1996) cited a study financed by the National Institute on Aging, which predicts that the 65 and older population will grow from one in eight today to one in six by 2020. In less than 25 years, the elderly in the nation will total 53.3 million. This is a 63% increase over the current population of 33 million older Americans. El Nasser and Stone (1996, p. 6) quoted Richard Suzman, the National Institute on Aging's head demographer, as saying, "The aging of the 75 million-strong baby-boom generation could have an impact on our society of equal magnitude to that of immigration at the turn of the century." Just as the generation of baby-boomers strained the educational system when they were young and now compete fiercely for jobs in todays market, they will place an unheard of challenge on health and social services as they age, according to the American Association of Retired Persons.

Twenty-five percent of our population lived 65 years or more in 1900, but in 1985, seventy percent survived to 65, and thirty percent lived to be 80 years of age or more. The U.S. Census Bureau projects that the 65-74 age cohorts will increase by 24% and the 75-84 age group is projected to grow by 50%. The fastest growing segment of the population, however, is the 85 + age group who will increase by 130% over the same period

of time (Krupa, 1996). Longino (1988) argues that the growth of the extremely old is not new, but the new fact is that the sheer number of old-old (85+) persons is so vast that it will have major impact on the health care and social service system.

The demographic surge of older adults in the United States is reflected in the State of Missouri. El Nasser and Stone (1996) use U.S. Census Bureau data to show that between 1993 and 2020, Missourians over 65 will grow by 45%. During the same time period, the Missouri population over 85 will increase by 61%. St. Charles County has similar census and projected data as listed in Table 1 (Hospital Industry Data Institute, 1996, p. 183).

The younger, active elderly are growing in smaller proportions than the old and old-old population. Figure 1 illustrates that by the year 2001, there will be a 19% growth rate for the 65-69 year old cohort group, while the 70 to 74, 80 to 84, and 85+ cohorts are projected to increase by 27%. Moreover, a significant 38% growth rate is projected for the 75-79 year old age group. Hooyman and Kiyak (1996) predict that this aging in place phenomena will create the need for long term care services and residential arrangements which accommodate the limitations and impairments associated with the more frail and dependent segment of the population .

Table 1
St. Charles County census data and projections

Population Characteristics	1980 Census	1990 Census	1996 Census	2001 Projected	Xchng 90-96
Population	144,108	212,907	250,038	280,155	17.4
PCT Over 65	6.0	6.9	8.1	9.0	17.6
Households	46,471	74,331	89,154	100,983	19.9
Pop/Households	3.1	2.8	2.8	2.8	-1.9
Families	38,620	57,815	68,466	76,727	18.4
Housing Units	50,027	79,113	96,087	108,836	21.5
Pop Grp Qtrs	1,283	2,225	2,237	2,250	0.5

Population By Age and Sex

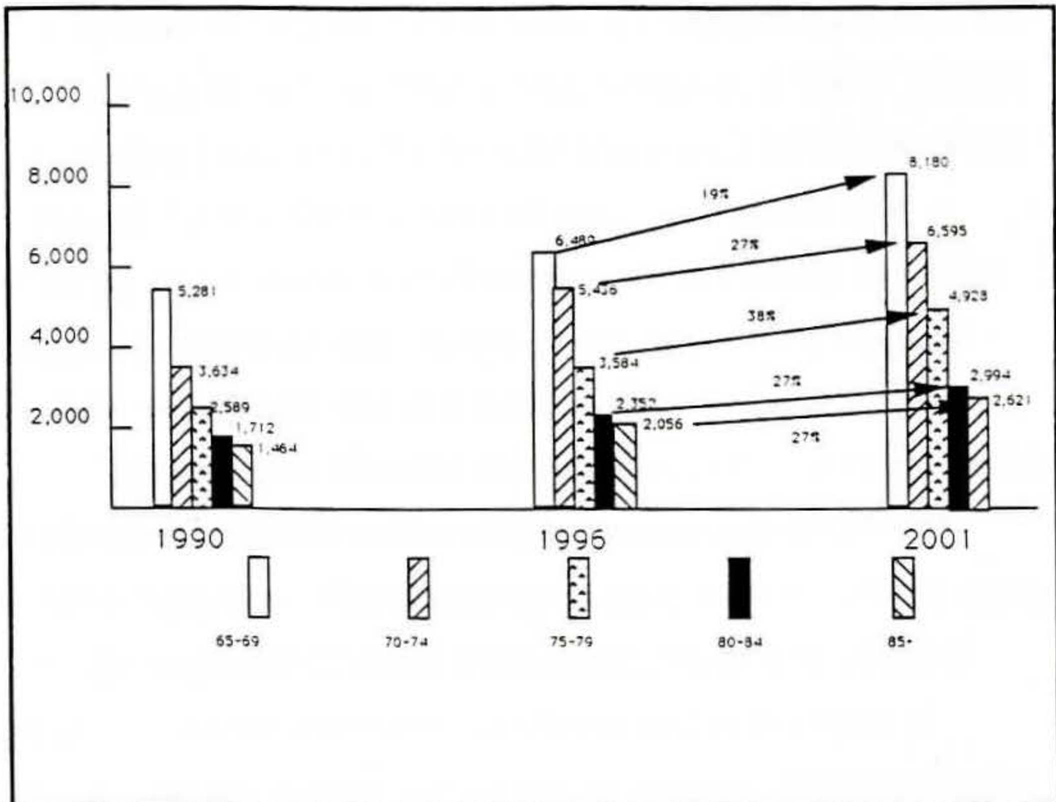
	1990 Census				1996 Estimate				xchng	2001 Projected			
Age	Total	%	Male	Female	Total	%	Male	Female	90-96	Total	%	Male	Female
0-4	19,225	9.0	9,983	9,242	21,265	8.5	10,946	10319	10.6	22,600	8.1	11,618	10,982
5-9	19,076	9.0	9,712	9,364	21,602	8.6	10,973	10629	13.2	22,858	8.2	11,537	11,321
10-14	16,937	8.0	8,610	8,327	19,738	7.9	10,040	9698	16.5	21,768	7.8	11,041	10,727
15-17	8,956	4.2	4,586	4,370	10,669	4.3	5,460	5209	19.1	12,073	4.3	6,182	5,891
18-20	8,078	3.8	7,034	4,044	7,182	2.9	3,599	3583	-11.1	9,380	3.3	4,738	4,642
21-24	11,197	5.3	5,410	5,787	11,719	4.7	5,881	5838	4.7	12,296	4.4	6,224	6,072
25-29	20,267	9.5	9,884	10,383	19,719	7.9	9,536	10226	-2.5	17,596	6.3	8,430	9,165
30-34	22,277	10.5	10,997	11,280	22,976	9.2	11,313	11663	3.1	24,149	8.6	11,984	12,165
35-39	19,148	9.0	9,392	9,756	22,894	9.2	11,219	11675	19.6	22,527	8.0	11,066	11,461
40-44	16,946	8.0	8,498	8,448	20,835	8.3	10,426	10409	22.9	23,582	8.4	11,721	11,861
45-49	12,737	6.0	6,580	6,157	18,667	7.5	9,481	9186	46.6	21,537	7.7	10,843	10,694
50-54	9,328	4.4	4,795	4,533	13,659	5.5	5,778	6881	46.4	19,360	6.9	9,591	9,769
55-59	7,565	3.5	3,962	3,603	10,573	4.2	7,343	5230	39.9	14,269	5.1	7,012	7,257
60-64	6,500	3.1	3,148	3,352	8,220	3.3	4,214	4006	26.5	10,843	3.9	5,396	5,447
65-69	5,281	2.5	2,480	2,801	6,849	2.7	3,329	3520	29.7	8,180	2.9	4,103	4,077
70-74	3,634	1.7	1,571	2,063	5,436	2.2	2,403	3033	49.6	6,596	2.4	3,074	3,521
75-79	2,589	1.2	974	20,220	3,584	1.4	1,446	2138	38.4	4,928	1.8	2,016	2,912
80-84	1,712	0.8	532	1,180	2,352	0.9	808	1544	37.4	2,994	1.1	1,082	1,912
85+	1,464	0.7	328	1,136	2,056	0.8	490	1555	40.4	2,621	0.9	673	1,948
Median age	30.6		30.2	31.0	32.8		32.4	33.3		34.5		33.9	35.0

Income Characteristics

Household	1979		1989		1996		2001		Xchng
Income $	Number	%	Number	%	Number	%	Number	%	89-96
Under 15,000	12,223	26.3	8,462	11.3	8,468	9.5	8,764	8.7	0.5
15,000-29,999	22,228	47.8	15,465	20.8	15,495	17.4	15,156	15.0	0.1
30,000-49,999	10,278	22.1	24,339	32.7	26,019	29.2	24,825	24.6	6.9
50,000-74,999	1,291	2.8	18,582	25.0	23,987	26.9	28,459	28.2	29.1
75,000 and above	451	1	7,499	10.1	15,185	17.0	23,779	23.5	102.5
Median HH Income	22422		40323		49144		51173		14.4
Ave. HHold Income	23715		43721		51346		55502		17.4
Per Capita Income	7677		15343		18379		21151		19.8
Median Fam. Income	24,166		45,084		51,629		57,014		14.6

Source: Census Estimated and Projected Data
1996 Hospital Industry Data Institute
Unity Health System Corporate Planning

Figure 1.
St. Charles County over 65 elderly growth rate by cohort population.



Source: Census Estimated and Projected Data
1996 Hospital Industry Data Institute
Unity Health System Corporate Planning

Health and Chronic Disease of the Older Adult

In an overview of older adults in the United States, Carter, et. al. (1989) provided data on a study which illustrates that the over 65 population are a heterogeneous mixture, and that it is imperative to include factors other than chronological age when evaluating older adults. The study showed that most older Americans continue to live in the community, are independent in their daily activities, are cognitively intact, and have a positive view of their health. However, a major concern this country faces as older persons experience longevity is the likelihood for the development of multiple, chronic and disabling impairments and illnesses with increasing age. The financially deprived and the oldest-old (85+) have need for personal health care and are high users of health services.

The American Hospital Association (1990) outlined health problems of the older adult which are characterized by numerous factors. Eighty-eight percent of adults over 65 have a chronic condition of some type compared to 17% of those under 65. There is a higher incidence and prevalence of cardio-vascular disease, malignant neoplasms, cerebrovascular disease, glaucoma, dementia, and diabetes. Physiological changes, such as varying responses to medications, have secondary ramifications which affect treatment. Older adults experience multiple illnesses in which therapy for one may worsen another condition. Functional disabilities frequently accompany the chronic diseases and major illnesses of the older population. Although the 65+ population comprised only 12.2%

of the population in 1988, they accounted for 45 percent of hospital inpatient days and 34% of admissions. The 85+ adults are most likely to need medical and supportive services. They are more frequently hospitalized and are at increased risk of complications due to hospitalization.

Morley (1996) considers several challenges to our health as we age. Heart disease, cancer, and stroke account for 75% of all deaths for men and women over 65. Mortality rates for cancer have risen due to the prevalence of lung and prostate cancer which is the leading cause of death for men from 65-85. Breast and colon cancer are the leading cause of death for women over 65. Eighty-one percent of deaths from influenza, pneumonia and other infections occur among people who are 65 and older. Morley refers to the challenges of disabling diseases which are not fatal but impair function. In America, twenty-four percent of persons 65 and over have limited activities due to heart disease, 23 percent because of arthritis, 10 percent due to vision problems, and 10% caused by orthopedic problems.

The Frail Elderly

Mace and Rabins (1991) described Alzheimers disease, as a form of dementia which impairs intellectual functioning and gradually progress from forgetfulness to disability to death. It usually occurs after age 65. It increases in frequency with age, and is the most frequent cause of irreversible dementia in adults. Alberts (1995) finds current trends which point to the

probability that nearly half of the eight-five plus Americans will eventually develop Alzheimers.

According to the Health Care Advisory Board Company (1996), the older population are the sickest of the sick. Three or more chronic conditions plague 13% of the elderly, 9% are unable to rise or transfer from bed to chair, and 10.2% of all hospitalized seniors discharge to a nursing home. They report that 25% of persons between 65 and 74 and 32.4% of the 75+ group report fair to poor health. There is an increasingly restrictive lifestyle due to disability. In the 75+ age group, 47.8% have a severe disability, and 45.6% have a limitation on activity. Seniors are heavy consumers of medications which place them at a great risk of adverse drug reactions. They consume on the average of 14.4 prescriptions per year, and 28% fill more than twenty prescriptions per year. The percentage of patients experiencing adverse drug reactions increases by 56% as the numbers of drugs taken concurrently increases from 2 to 20. Adverse drug reactions cause 17% of senior hospitalizations.

At the Health Care Advisory Board's National Conference on Medicare Strategy (1996), it was reported that the over 65 adult have 2.5 times as many physician visits, use 6 times as many prescriptions, and are admitted to hospitals four times more often than their under 65 counterparts. Physicians spend less time with older adults than younger patients. According to physician interviews, 45% indicated that not having enough time to teach patients was a significant problem. Scenarios in

which too little time spent with the physician, poor access to specialist care, minimal pharmacy coordination, non-compliance with chronic disease management, uncoordinated inpatient care, and little attention to follow-up holistic medical and social service needs lead to poor outcomes for older patients.

Functional Disabilities with Age

When an older person experiences an acute illness, requiring hospitalization, a spiraling downward effect is frequently the outcome. As reported by the Health Care Advisory Board Company (1996), one-third of seniors being discharged from hospitals have reduced function in any of six activities of daily living. Seniors with reduced function are shown to soon return for care. Twenty-seven per-cent of seniors with reduced function upon discharge are rehospitalized, and 15% become institutionalized in a nursing home within three months of discharge.

The correlation between aging and increasing functional disability is measured in the individual's ability to independently perform activities of daily living (ADL), such as bathing, dressing, eating, toileting, and tranferring or locomotion. Selker and Broski (1988) reported that the need for increased assistance with ADL's increases with age. The prevalence of limitations doubles as one moves from the young-old to the old cohort group and triples as one moves to the old-old cohort group. The number of functionally dependent elderly will increase as the prevalence of chronic

conditions associated with disability increases. The older age groups are increasingly female, and older women have higher prevalence rates than men for chronic conditions associated with arthritis, osteoporosis, hip fractures, and hypertensive disease .

The Catholic Health Association (1988) quoted the National Long Term Care Survey prepared by Duke University which found increased functional dependencies with increased age. The ADL Limitation Score ranges from limited disability with 1 ADL deficit to disabled with 3 to 4 ADL dependencies. Of the young-old (65-74), 10.5% scored dependency levels ranging from limited to disabled; 44% of the old (75-84) and 39.5% of the old-old (over 85) were functionally dependent with scores ranging from limited to disabled.

This ADL Limitation Score does not account for those individuals who require additional assistance with instrumental activities of daily living (IADLs), such as meal preparation, taking medicines, making a phone call, managing money, or shopping. The University of Missouri, St. Louis (1990) conducted an assessment of older adults needs by geographic regions for the Missouri Department of Social Service. Table 2, an excerpt from the document, provides insight into the unmet IDAL needs of older adults in several Missouri Counties.

Table 2

Number of older adults with unmet needs by geographic region.

Service	Franklin	Jefferson	St.Charles	North	Central	South	TOTAL
1. Home delivered meals or Meals on Wheels	263	378	229	1198	521	1159	3748
2. Visiting nurse	395	566	457	1796	1042	1159	5415
3. Home health aid	263	755	686	1198	521	1680	5103
4. Congregate meals	659	944	914	1796	2033	3998	10344
5. Homemaker services for the elderly	659	755	686	1796	521	579	4996
6. Legal Assistance	659	755	914	2994	0	2839	8161
7. Home repair services	659	1114	914	5988	6152	11357	26184
8. Help locating different housing	395	755	229	598	521	1159	3657
9. Food Stamps	527	755	457	1796	521	2839	6895
10. Surplus food	263	755	457	2395	521	2260	6651
11. Medicaid	132	1114	457	3593	1042	1680	8018
12. Money to pay utility bills	263	1303	0	2994	1512	2260	8332
13. Respite care (time off from caring for ill or disabled person over age 60	263	378	0	598	0	1680	2919
14. A nursing home	132	189	0	0	0	0	321
15. An adult day care center service	263	189	0	598	0	0	1050
16. Arts, culture, or recreation programs	1172	944	457	2994	4588	3998	14153
17. Telephone reassurance (checking health of older person)	527	566	229	1796	1042	1680	5840
18. Help finding a job	0	755	229	1198	2033	1159	5374
19. Tax Assistance	263	944	686	1796	4067	3419	11175
20. Assistance filling out insurance or other forms	395	755	686	1198	1512	579	5125
21. Health screening	263	755	686	1796	1512	1159	6171
22. Help from someone to get all the services you need (case manager)	527	1302	1143	2994	1042	2260	9268
23. Transportation, Medical	132	189	229	1198	521	2839	5108
24. Transportation, Non-Medical	132	189	229	589	521	3419	5088

Source: University of Missouri, St. Louis - Dept. of Social Service, 1990.

Home or Nursing Home

In an AARP (1992) demographic profile of older Americans, 67% of older noninstitutionalized persons were living in a family setting in 1991. Only 5% of the 65+ were living in nursing homes in 1987, but the percentage increased dramatically with age. One percent of the young-old population (65-74) were living in a nursing facility while 5% of the 75-84 year olds and 25% of those over 85 persons were institutionalized.

The National Task Force on Gerontology and Geriatric Care Education in Allied Health explored trends occuring in our aging society and implications of these trends. Their findings, as reported by Selker and Broski (1988), indicated that the rates of health services utilization are higher among the older population. Between 2000 and 2040, the 65-74 year old population in long term care facilities will increase by 63%; the 75-84 year old group will increase by 95%; and those over 85 will increase by 165%.

Over 85% of Americans of all ages are either underinsured or uninsured against catastrophic and long term care costs. Many older persons will be unable to afford to pay for long term care needs, which will intensify pressures on family caregivers to provide care to older relatives. The number of individuals living at home or in the community who receive formal long term care is increasing due to policies and reimbursement aimed at deinstitutionalization. Because the

number of older persons needing care will increase as people live longer, the need for care will outstrip the ability of public sector or private funds to pay for formal care. With more women in the work force, declining average family size, and increasing divorce rates, there will be an erosion of the ability of families to provide care while the need for informal care is increasing (Selker & Broski, 1988).

Caregivers

> In our twenties and early thirties, we acquire this second family in which we are the responsible adults. We may imagine we're starting a family from scratch. But we cannot detach ourselves so easily from our first, our original family, from that intricate web of relationships which connect us, albeit imperfectly, to each other. (Viorst,1986, p. 248)

Families provide nearly 80% of in-home care for older relatives with chronic ailments. Almost 29% of primary and secondary caregivers are daughters, 23% are wives, and more distant female relatives comprise 20% of caregiver responsibilities. One-third of the informal caregivers are over 65 (Kincade et. al., 1996). Research depicts caregivers who perceive themselves to be in poorer health than peers who do not have caregiving responsibilities (Alberts, 1995).

Hooyman and Kiyak (1996) find the current expectations for informal care by families to be unrealistic because of cost, demographics and social trends. The care is more difficult and over a much longer period of time than when life expectancy

was less and only 4% of the population was comprised of elders. The average American woman can expect to spend more time caring for an aging parent than caring for children. In-home care such as social work services, chore services, homemaker and home health aides, home-delivered meals, in-home respite, friendly visiting, and telephone reassurance which are delivered directly to the older person have become necessary to reduce the demands of care on the family or informal caregiving.

The Stress of Caregiving

Caregiving can negatively affect the caregivers health, employment, personal freedom, privacy, and social relationships. Most people are unprepared to meet the expectations of providing emotional support, financial aid, assistance with instrumental activities of daily living inside and outside the home, and mediate with agencies to obtain services. Emotional reactions are experienced differently by caregivers, but include such feelings as anger, sadness, guilt, discouragement, isolation, loneliness, embarrassment, helplessness, grief, depression, worry, and anxiety. Although each caregiver may experience stress differently, the importance of recognizing feelings cannot be overemphasized. Having knowledge of the potential for psychological reactions may affect the judgement used in acting upon the feelings listed above (Mace and Rabins, 1991).

Hooyman and Kiyak (1996) describe the objective burden of caregiving as the reality demands that confront the

caregiver, such as symptomatic behaviors of the illness, disruptions in family life, income, and problems with service systems. The physical stress of caregiving manifests itself in health problems, and increased use of prescription drugs. Subjective burden is described as the feelings aroused in caregivers. The emotional burden increases the rates of depression in older women who are frequent caregivers. Although the number of educational programs and support groups has increased in the last decade, funds to reduce the strain on caregivers are limited. About half of the families providing care do so without outside assistance. This lack of formal support resources increases the caregiver's stress.

Caregivers who find themselves in stressful situations over a long period of time may be unable to cope. Mood swings and depression have a negative effect on the health and well-being of the caregiver and patient. Carter (1994) outlined three stages of burnout in which eagerness to do good changes to lack of motivation and productivity in the second stage. More serious problems occur in the third stage in which physical and mental stress are evident. Caregivers who cannot cope with the stress may turn to alcohol or drugs. Hooyman and Lustbader (1988) find that a consequence of ineffective coping is abuse of the patient. The abuse can be financial, emotional or physical.

The Cost of Informal Caregiving

The cost of financing home-based care creates additional pressure on the caregiver. Fogel (1995) finds that Alzheimer's victims living in the community receive approximately 286 hours per month of unpaid care from family members. The care includes behavior management, and assistance with daily living, social and recreational activities. The annual cost of this informal care is calculated to be over $34,000 if it were to be provided by people who were hired as caregivers. The primary caregiver reduces working hours or retires to do the caretaking. However, reducing income may mean that funds will be unavailable if nursing home placement becomes necessary.

The inability to afford long term placement or the need to deplete family funds to be eligible for medicaid creates a tremendous anxiety for the primary caregiver and the entire family. According to Weiner (1996), research indicates that a quarter of discharged Medicaid residents were admitted as private pay residents, but went on Medicaid when they exhausted their savings. A substantial proportion of Medicaid nursing home residents were not poor before they entered the facility. They became impoverished by paying for the cost of nursing home care.

The Impact of Caregiving on Business

Caregiving takes its toll on the business world. Researchers warned that the $29 billion a year in lost productivity in the U.S. is likely to grow as the population ages.

According to AARP, eldercare is something that everyone will likely experience in their lifetime. The National Alliance for Caregiving survey indicates that 23% of households have caregivers. The average caregiver spends 18 hours a week caring for her 77 year old mother. Twenty percent of caregivers are between 18 and 35 years of age. ("Caregiving Costs," June 19, 1997).

There are millions people who juggle jobs and caregiving responsibilities. One in four employees over 40 has eldercare responsibilities. The care they are giving to the older adult is often without experience, assistance or training. By 2005, 37% of workers in the U.S. will be caring for parents, and this figure will jump to 50% when the majority of baby-boomers reach 65 in the year 2050 ("Eldercare Benefits," 1996).

Sixty percent of the caregivers are regularly late for work, leave early, and take long lunches due to caregiving responsibilities. Ten percent lose six days annually, and seventeen percent quit their jobs entirely ("Caregiving Costs," June 19, 1997). Companies are beginning to recognize the impact of caregiving on their workforce. One estimate indicates that employers lose $3500 annually for each worker with eldercare responsibilities. The Bureau of Labor Statistics says that 31% of employees in private companies were provided eldercare assistance at their workplace in 1993. This was a 22% increase from 1991. Typical eldercare programs include seminars, counseling, referral services, and research ("Eldercare Benefits," October 11, 1996).

In 1994 two reports on advances in workplace elder care benefits were released by the U.S. General Accounting Office. One was for public sector employees and one for the private sector. Lank, et. al., (1995) quoted a paragraph from the GAO/HEHS-94-64 Public Sector Elder Care which provides insight into the dilemma this country faces as greater numbers of women who have the primary responsibility as caregivers enter the workforce.

> Because women's participation in the workforce and the number of disabled elderly have grown, more employees are caring informally for older Americans in their homes and communities. Approximately two million working Americans provide informal caregiving assistance to their disabled elderly relatives, including help with eating, bathing, moving around the home, housework and financial management. Nearly three-quarters of all caregivers are women, many of whom are employed outside the home. An additional six million employees have a disabled spouse or parent who may also require help with these and other activities. As the population ages, the number of employed caregivers is expected to grow. Potential caregivers, spouses and children of disabled elders currently account for about 9 percent of the workforce of full time employees. (Lank, et. al., 1995)

Fahey (1996) encourages businesses to recognize that valued employees have eldercare responsibilities, and find

ways to ease their burden for humanitarian and productivity reasons. He finds that a retooling of the reimbursement system under the entitlement programs of the Health Care Financing Administration (HCFA) is necessary to assist caregivers manage the long term decline in functional and health status of older adults. Lank, et. al. (1995) also calls for a disability model of reimbursement rather than the present acute care oriented reimbursement model envisioned by the original framers of the Medicare bill which will help family caregivers deal with their responsibilities.

Long Term Care

> The overall health of an individual is so inter-dependent with his/her physical, emotional, social, and spiritual well-being, and because the needs of the elderly are often chronic and longer-lasting in nature, a wider spectrum of needs and services must be assessed to evaluate the status of care to the elderly in any single community and the networking that may be necessary to address the needs. This spectrum can include, but is not limited to, services in the following areas: acute inpatient, home health care, extended care, financial/insurance mechanisms, retirement and legal planning, community outreach, medical and paramedical care, outpatient ambulatory, pastoral care services, wellness/health promotion, housing/ assisted living, special senior or caregiver support. (Sisters of Mercy Health System, 1988, p. 4)

Long-term care is a critical and controversial issue facing our aging society, policy makers, health care providers, and caregivers. Torres-Gil and Douglas (1991) defined long term care as health care, personal care, and social services delivered over a period of time due to loss of or failure to acquire a degree of functional capacity. Long-term health care and support services are primarily focused on older persons because of the high incidence of chronic, degenerative, and disabling conditions associated with this age group. Long term care includes both formal and informal sources of support. Informal caregivers include family members, friends, and neighbors who provide between 70% and 85% of all long term care. Formal long term care, which was traditionally considered to be nursing home care, consists of various services provided in the home, the community, and institutions.

Hooyman and Kiyak (1996) describe long term care as the array of services needed to enable the chronically disabled to maintain physical, social, and psychological functioning for conditions which do not need constant medical monitoring. Torres-Gil and Douglass (1991) describe the services to include home care, respite care, adult day care, hospice, nursing homes, skilled home health, housing and independent living with coordinated services, nutritional programs, senior centers, and transportation.

Long-term care is further described by Hooyman and Kiyak (1996) as a constellation of assistance and social services needed to perform activities of daily living (ADLs) and

instrumental activities of daily living (IADLs). Skilled care for medically related problems and constant supervision for people with cognitive impairments comprise additional elements of long term care.

Long term care is expensive. The cost of a nursing home averages $38,000 annually. Skilled care at home, if visited three times per week for two hours per visit for a year would cost about $12,300. Personal care at home for two hours per day, three days per week by a home health aide will cost an individual about $8,400 (A Shopper's Guide, 1996). The average cost of adult day care is $30-$40 per day (Cox & Reifler, 1994). Assisted living facilities cost between $1,700 to $1,900 per month (Moore, 1996).

One third of all nursing home care is paid for privately by the individual person or their family, and approximately one-half is funded by state Medicaid programs. Medicare will cover the cost of some skilled care, but long term care costs are generally not covered by Medicare, Medicare supplements, or major medical insurance. Home health aides providing custodial care is not covered by Medicare unless the patient is also receiving skilled nursing or therapy, and the custodial care is part of the skilled treatment plan. Medicaid assistance is available for some community-based services if the federal poverty guidelines for income and assets are met. If the individual has assets which are spent down or used up on health care, he/she can become eligible for Medicaid. (A Shopper's Guide, 1996)

Federal and State Policies

Old age has become the rule, not exception, and the third age, a relatively new appendage to the life course is a period which may be considered by social revolutionists as unnecessary. It is a time when one is not needed to produce or reproduce. It is a time for the frail elderly to be dependent. The progressive public policy initiatives of the past sixty years are being intensely scrutinized by all who deal with the economic and human cost of entitlements. Medicare, Medicaid, and the Older Americans Act are prime targets for budget cut. The challenge will be to find a way to manage the miracles of age brought about by the technical skills of our society. During this contentious period, the frenzy to balance the budget will dramatically change entitlement programs as well as state and federal relationships. As society faces the challenge of aging to the economy, government, family, church, and the older individual, we will have more to do with less. (Fahey, 1996).

Federal and state policies related to healthcare, community-based social services, housing, and service coordination have been initiated over the years. They have resulted in our current system for long-term care which a vast, complex, and multifaceted mix of services, agencies, and programs. Comprehensive systems to fund, coordinate and administer long term care are lacking at the federal and state levels (Torres-Gil and Douglass, 1991).

Meyer (1996) notes that the current stereotyping of older adults as affluent, selfish and greedy needs to be pitted

against realities. He reminds readers that senior citizens are not as well off as the senior bashers would have us believe. In 1994, only 9% had incomes over $50,000, but 12% lived below the poverty level and nearly 20% of the group have incomes below 125% of the poverty level. Three-fifths of the women over 65 are widowed or single and are three times as likely as men to live below the federal poverty level. The median white household headed by a person over 70 has $10,000 in net assets. The median black and latino household headed by an older person has no assets.

Long-term care for chronic illness or functional disabilities are the largest single threat to the economic security of all older individuals except the very wealthy. Federal and state initiatives have created a fragmented, unevenly funded and uncoordinated system of programs, agencies, and funding sources. Community-based services may be part of a research and demonstration project, or restricted to geographic areas and economic groups. Although long-term care is vast and accounts for 24% of all health care expenditures for older persons, it is perceived as a residual function to be undertaken when medical care has not succeeded by the current health care system which emphasizes primary and acute care (Hooyman and Kiyak, 1996).

The two major programs for funding the health care components of the long term-care system are Medicare and Medicaid, Titles XVIII and XIX of the Social Security Act. Medicare provides health insurance to persons over 65, while

Medicaid's original intent was to serve as a third-party insurance program to assist in the payment of medical care for low-income persons regardless of age. Both programs were enacted in 1965. Title XX of the Social Security Act , the Older Americans Act (OAA), and the Medicaid home and community services waiver program are the primary programs providing social supports for the elderly. Section 8, Housing and Community Development Act, and Section 202 are the two primary public-housing programs for older persons (Torres-Gil & Douglas, 1991).

Medicare and Medicaid

Medicare Part A is The Hospital Insurance Program which covers inpatient hospitalization, and post-acute care in skilled nursing facilities, rehabilitation facilities, long term care hospitals, and home health agencies. Part B is the Supplementary Medical Insurance Program. It is voluntary and covers physician fees, outpatient services, durable medical equipment, and home health visits. Aside from a few exceptions, Medicare does not cover home and community-based long-term care costs. In addition it does not cover dental care, eyeglasses, hearing aides, and other items or services which may be necessary to remain functionally independent (Torres-Gil and Douglas, 1991).

Payments to post-acute providers are rapidly increasing due to changes in medical care practice patterns, improved rehabilitation techniques, and increased service capacity. Almost 25% of Medicare beneficiaries receive post-acute

services within 30 days of a Medicare-covered hospital stay. Forty percent of the care was rendered in skilled nursing facilities, and home health agencies provided care to more than half of the patients ("Eldercare Benefits," 1996).

Medicare spending growth per capita was less than or equal to private spending through the early nineties. In the last year, seniors spent 15% more income on premiums, deductibles, copayments, and other items not covered by Medicare than working Americans under 65. The out-of-pocket expense for seniors grew 112% between 1987 and 1994, while their income rose only 28%. The elderly living under the poverty line spent 40% of their income on health care (Meyer, 1996).

Medicaid, a means-tested program, is limited to low income elderly. Title XIX provides federal matching funds for state programs. The state programs provide funds for inpatient hospital care, physician services, skilled nursing facilities, laboratory and x-rays, home health, outpatient care, and screenings. Dental care, eyeglasses, and intermediate nursing home care may also be provided under Title XIX. Over half of the Medicaid budget is spent on nursing home care, which reduces the amount of money spent to assist older persons to remain independent in the community. Increased attention is being given to the provision of non-institutional services in an effort to contain cost and encourage independence(Torres-Gil and Douglass, 1991).

In 1985, nursing home costs were 35.5 billion, and home health services cost 9.1 billion. The public share of $9.5 billion was paid by Medicaid. Private expenses for nursing home care was $16.2 billion (Torres-Gil and Douglas, 1991). Wiener (1996) reports that in 1995, 33% of Medicaid expenditures were for long-term care services. In 12 states, long-term care accounts for at least 45% of Medicaid expenses; close to three fifths of Medicaid long term care expenditures are for older persons; Medicaid accounts for 62% of government spending for nursing home and home care in 1993; most Medicaid long-term care spending for older persons is for nursing home care where the costs for 69% of residents in 1994 were partly financed by the program.

Risk-based models of managed care involve a pre-payment of a fixed monthly amount for an established array of services. The contractor bears the risk. Medicare and Medicaid beneficiaries enrolled in managed care models are growing rapidly. Medicaid enrollments has increased from 1991 to 1994. Many states are also enrolling Supplemental Security Income (SSI) recipients in their managed care programs. Enrollment in Medicare managed care plan has risen 27% from 1991 to 1994 (Mollica, 1995).

Medicare risk contracting is picking up steam, and the Health Care Financing Administration (HCFA) is making regulatory changes which would smooth the way for greater Medicare risk contracting. Fueling the growth of the risk market for Medicare is the fact that employers are encouraging

retirees to join by paying for all or part of their premiums. Proponents of Medicare risk HMOs consider it a good deal for seniors because it offers more benefits, such as medications and preventive care. It also involves less paperwork, and offers coordination of services to help older adults navigate the complex healthcare system. However, HCFA is monitoring risk and access problems which have been felt by the disabled elderly (Kertesz, 1995).

Community-Based Social Services

Community-based services are designed to meet the environmental, social and medical needs of the older and disabled person. The Older Americans Act (OAA) provides funding for nutrition services, transportation, ombudsman programs, legal aide, and other social services. OAA services are administered through the area agencies on aging. They are available to anyone over 60, regardless of financial need. The 1987 amendments to OAA authorized funding for nonmedical home-care services. Services under this act are imperative in assisting older persons to remain as independent as possible in the community and resist institutionalization (Torres-Gil and Douglas, 1991).

Home health involves the use of homemaker and chores services, home health aides, nurses and physicians. Adult day cared provides essential long-term care services in an outpatient setting. Adult day care serves as a respite for caregivers who need time off or who need someone to provide care while they go to work. It can have social and/or medical

components in which services range from rehabilitation and meals to recreation, supervision, and medical care.

Other components of community-based services include home delivered meals; congregate meals and educational programs at senior centers and adult foster homes; hospice programs for the terminally ill at home, in the community, or in the hospital; adult protective services and guardianship programs to protect the older person from exploitation and abuse. Some states provide the community-based services for the poor only while other states provide services for a fee or private funds. Those with adequate financial resources, however, have limited ability for participation in these programs (Torres-Gil and Douglass, 1991).

Service Coordination

The federal government has instituted a series of waivers that permit states to use Medicare and Medicaid funds to purchase services and develop programs beyond the scope of the existing legislation in an attempt to create coordinated programs which are more cost efficient, minimize institutionalization, and improve care management for the older person. Section 2176 in the 1981 Omnibus Reconciliation Act grants waivers for states to use Medicaid funds to finance a range of community-based, long-term care services. Section 222 of Public Law 93-402 authorizes projects that waive existing Medicare restrictions on covered services.

Waivers create opportunity for home care, preadmission screening, case management, social home care and

transportation. Demonstration programs utilizing preadmission screening and/or case management as mechanisms for coordinating community-based long term care include: 1.) the Multipurpose Senior Program in California which relies on case managers to help clients access existing services and 2.) Social Health Maintenance Organizations (S/HMOs) and Programs for All Inclusive Care which utilize capitated reimbursement to create financial incentives utilize a continuum of social and medical programs to encourage deinstitutionalization of the frail elderly (Torres-Gil and Douglass, 1991).

Omnibus Budget Reconciliation Act

In 1983, the prospective payment system was designed to suppress increases in Medicare Part A costs by paying hospitals a set amount for specific conditions, called diagnosis-related groups (DRGs). The prospective-payment system began the trend of discharging sicker patients on a quicker basis to skilled nursing facilities and home with home health for skilled services. Throughout the history of nursing homes, care has been controversial, but the advent of DRGs increased policymaker and public concern about the quality of care in nursing homes to which patients were being discharged. Nursing homes had been regulated under the Older Americans Act since the 1970s. In 1983, the Health Care Financing Administration commissioned the National Academy of Sciences' Institute of Medicine (IOM) to study nursing home regulations authorized by the Older Americans Act, and make recommendations for change. In 1986, the IOM issued a

report, Improving the Quality of Care in Nursing Homes. It resulted in Congress mandating several provisions to improve care which were implemented nationally in 1990 (Rantz, et.al., 1996).

The IOM Report, a 415 page document, concluded that care in nursing homes was extremely deficient. The report served as a blueprint to formulate the Nursing Home Reform Act enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987. The law required that nursing homes improve the quality of care, quality of life, and rights of residents. It defined specific standards to qualify for Medicare and Medicaid reimbursement, and mandated staffing and staff standards. It regulated surveys and certification, and developed enforcements and sanctions for facilities that are out of compliance with the regulations. The standards under the Nursing Home Reform Act focused on the care provided to residents and the outcome of the care or effect on the well-being on the resident (Coleman, 1991).

Managed Care and Integrated Delivery Systems

A goal of consumers, providers, practitioners, and policy makers is to create a method for financing a cost-effective system to support quality health care in the most appropriate setting. Managed care organizations (MCOs) or integrated delivery systems (IDSs) offer the potential of reaching the goal by bridging separate funding streams to deliver the full spectrum of preventive, acute and long-term services. An IDS avoids the provision of services in institutional settings, and

the provision of more services than necessary due to reimbursement incentives. Managed care calls for a broad array of strategies to improve health care services by increasing earlier access to effective care and reducing unnecessary and ineffective care (Mollica, 1995).

A continuum of formal long term care services to complement and support the informal caregiver should be incorporated into an integrated system. However, Torres-Gil and Douglas, (1991) find that the actuality of long-term care is not comprehensive and integrated. Some services, such as skilled home health and sub-acute hospital based units may be included in an integrated delivery system, but long-term care and services is fragmented, limited, complex, difficult to understand and even harder to access.

The Catholic Health Association (CHA) of the United States (1995, p. 11) defines integrated delivery as, "The ability to provide comprehensive healthcare services through a coordinated, person-centered continuum designed to improve the health of people in a specified community within economic limits." Their vision for a healthcare delivery system is based on the belief that a coordinated continuum of healthcare services is the best way to serve persons, families, and communities. The Catholic Health Association (1995) views the continuum of services as a wheel, the spokes of which are integrated services coordinated to serve the person at the hub of the wheel.

Forces of change are propelling acute care hospitals, HMOs, physicians hospital organizations (PHOs), and other healthcare entities to align and affiliate into an integrated health care system. Integrated delivery relies upon non-acute and long term care providers, as well as acute and primary care providers. It is the preferred way for a healthcare system to serve people rather than have people conform to the system. It focuses on improving health in the community. It calls for collaborative action on the part of providers to the enrolled population by coordinating care across sites and integrating services in a continuum which is seamless. It mixes services and sites to meet needs, and is of benefit to the chronically ill and/or disabled. Care is financially, as well as clinically integrated (Catholic Health Care Association, 1995).

The Evolution of Integrated Care Delivery

The dramatically changing demographics in this nation call for long term care to partner and vertically integrate with acute and primary care systems. Traditionally, healthcare is viewed as having two totally separate systems, acute care and long term care. Each is considered to have different foci, goals, providers and practitioners, and lengths of stay. There are even different methods of reimbursement, demand, desired outcomes, methods of care, and cost drivers for the two separate systems. The conceptual framework of differences between the two systems can lead to complexity, fragmentation and access difficulties (Snow, 1995).

The Catholic Health Association (1995) describes an evolving view of healthcare as two circles which represent acute care and long term care. In the traditional view, the circles are completely independent of one another. The transitional view of healthcare is more progressive. There is some limited overlap between acute and long term care, but the connection is largely in how long term care can serve acute care.

However, in an integrated delivery system, the view of healthcare is transformed to one in which all providers are interdependent. There is only one circle representing both the acute and long term care industries. Healthcare for a specific population is managed across time and setting. Functional status and ability to perform ADLs will be key. The outcome of care in an integrated delivery system is sensitive to collaborative resources in order to be effective clinically and financially (Catholic Health Association, 1995).

An integrated system of care provides access to a myriad of health, social and long-term care services for the older adult and his/her caregiver so that it enables the individual to remain as independent as possible for as long as possible. It recognizes that acute flare-ups of chronic conditions can have devastating consequences for the older person's health and the cost of care. It can work for the elderly with chronic health needs by emphasizing cost-efficient behavior with health promotion and prevention programs to encourage the maintenance of health and functional status (Snow, 1995).

Integrating services do not interfere or conflict with one another. For example, monitoring medications prescribed by one physician do not conflict with treatment prescribed by another physician. Needed services are planned and coordinated to maintain the well-being of the older adult and enhance the quality of care. An interdisciplinary team made up of the physician, personal care attendant, home health nurse, social worker, and family come together to develop a plan to maximize the individual's functional capacity, rather than each discipline acting alone. Overall costs can be controlled in an integrated delivery system by allowing different service settings to work together for the individual's good, as well as the good of the health plan. By encouraging communication among providers, conflicts among providers and duplication of services can be avoided (Snow, 1995).

Program for All-Inclusive Care for the Elderly

An innovative model of integrated Geriatric care and financing is the Program of All-inclusive Care for the Elderly (PACE). The major goal of PACE is the prevention of unnecessary institutionalization in hospitals or nursing homes. Pace serves enrollees who are frail elderly certified by the state as eligible for nursing home placement, in day center and clinics. The average enrollee is 80 and has 7.8 medical conditions and is dependent in 2.7 ADLs. Fifty-five percent of the enrollees are incontinent, 39% live alone, and 14% have no informal support (Eng, et. al., 1997) .

The prototype for PACE is On Lok, which means happy, peaceful abode in Chinese. It began fourteen years ago in San Francisco, and has been successfully modeled in sites across the country. The service delivery system stresses comprehensive care that emphasizes prevention and early detection. It uses an interdisciplinary team for care management. It is a Medicare and Medicaid waiver program which receives monthly capitation payments from both programs. If patients are ineligible for Medicaid, they can pay privately. It answers the needs for frail elderly who reluctantly turn to nursing homes, and federal and state welfare programs challenged by runaway costs (Cleary, 1994).

According to Eng, et. al. (1997) the outcomes have been positive. There is a steady census growth, pleased patients and families, reduction in hospital admissions and institutional placement, controlled utilization of appropriate services, and cost savings to public and private payers. The PACE model for health and social services is a cost-effective coordinated system of care with integrated financing which have an appeal and applicability to providers and policy-makers whose goal is to provide high quality care in an era of shrinking resources.

Long Term Care Insurance

In a study by the Health Insurance Association of America, it was reported that the risk of needing long-term care by the general population over 55 is greater than 50%. The Health Insurance Portability and Accountability Act, which was signed into law in 1996 and became effective in January,

1997, created an incentive to purchase long term care insurance as a hedge against financial loss to individuals, families and employers. The act allows taxpayers to deduct premiums for long-term care policies. Employers can also deduct amounts they pay for long-term policies for their employees as well as their extended family members under group rates. Once the premium is combined with qualifying medical expenses, anything in excess of 7.5 percent of adjusted gross income will be deductible (Erler, 1996).

Although over 25% of the population do not know how they will pay for long-term care, and many mistakenly believe the government or their health insurance will cover it, people are starting to assume more personal responsibility for purchasing long-term policies. Long-term care insurance is purchased to avoid dependence upon other people for care, protect assets, and afford service for long term care needs at home, adult day care, or in an extended care facility. The typical purchaser in 1994 was 70 years old or more, and had an average annual income of $35,000. Policies are becoming more comprehensive. The average nursing home benefit is $85 compared to $72 in 1991. The average annual premium was about $1500 in 1994 ("Tax Break," February, 1996).

The Health Insurance Association of America finds that more single people are buying long-term care insurance, and that when married couples buy, 63% purchase policies for both spouses. People who purchase policies are twice as likely to agree that it is important to plan for the possibility of needing

long-term care insurance than those who choose not to buy. A greater percentage of purchasers chose policies which include home care benefits as well as nursing home benefits than in the early nineties. The daily benefit for home care is $78. Data suggests that insurers have a unique opportunity to expand their market while filling an important and growing void (American Association of Homes and Services for the Aging, 1996).

Most long-term care policies provide coverage for adult day care coverage, which allows a patient to receive services in a supervised setting while the employed family member goes to work. Another feature for family members or friends is the ability to be compensated for caring for a person in need of services in a home setting (Erler, 1996).

Housing

"If people start on the road toward frailty unnecessarily, and it is often related to housing [needs], there really is no going back. For lack of a nail, a kingdom is lost" (American Association of Homes and Services for the Aging, 1995, p. 13). According to Deets (1993), 85% of older Americans do not want to move. They want to stay where they are. However, many people cannot age in place because they cannot afford it or because they are not strong or healthy enough to maintain their own home. AARP is supporting the expansion of federal housing and supportive programs which will enable older people to live as independently as possible for as long as

possible. Innovative solutions in the private sector link shelter with services for older Americans.

Seniors will make strong efforts to remain at home as long as possible. At the American Society on Aging's annual convention, the message was that instead of growing old and moving out, more seniors are modifying their home and aging in place. Alterations and modifications made to the structure make it safer and enable independence. Changes include ramps for wheelchairs, widening doors and entrances, installing grab bars and hand rails, and modifying kitchens for easier meal preparation. Federal funds are available for modifications and some insurance companies are looking into supporting the effort because improving seniors home can improve health (Senior Services and Funding Report, 1997).

Housing is a major component of long term care. Section 8 of the Housing and Development Act was created in 1974 and provides subsidized rental assistance to low income persons. Section 202, also enacted in 1974, provides federal financing for the construction of housing for older and disabled persons. Funding is administered by the Department of Housing and Urban Development (HUD). Funds available through Section 8 and Section 202 are declining and both programs have had major cutbacks since the 1980s. HUD continues some on-going demonstration programs which provide congregate housing services to older persons such as the Congregate Housing Services Program, which assists older persons to remain in

their current residence as they age in place and require additional assistance (Torres-Gil and Douglass, 1991).

Approximately 365,000 persons who live in federally-assisted housing are frail, and this number will increase as the population ages. A large and growing number of frail elderly are at risk of institutionalization because supportive housing may not be available due to lack of coordination of such services, and resulting inaccessibility. Supportive services promote the option of independent living which is invaluable to the older, frail person. In 1992, Congress authorized the U.S. Department of Housing and Urban Development (HUD), under the National Affordable Housing Act (NAHA), to administer the Service Coordinator Program (SCP). The purpose of this program is to meet the needs of the elderly and disabled person living in HUD-assisted housing (KRA Corp., 1996).

Service coordination links services and housing. Its goals are to improve the quality of life and delay or avoid institutionalization by assisting residents to utilize supportive and health services they need. Commonly cited benefits include: promoting resident independence and control, alleviating isolation, reducing alcohol and substance abuse, improving physical and mental health and functioning of residents, preventing crisis situations, improving utilization of complex, fragmented, difficult to access services which aid in the reduction of hospitalization and nursing home placement (American Association of Homes and Services for the Aging, 1997).

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Service coordination has a role that is similar to care management, but it tends to have more of a group orientation and more opportunities for early intervention. According to Lanspery, it is more "macro", while care management is "micro". Rather than arranging for a service such as meals on wheels for an individual, the service coordinator's interventions may effect the entire housing complex, such as congregate meal service or transportation. The role of the service coordinator incorporates empowerment and community-building strategies to help older people be able to age in place; convince providers that the place to which service is delivered matters; support innovative ways of organizing services; assists housing managers and residents with housing concerns, such as safety and handicap accessibility; and deal with group issues, including communications, conflicts, and services (Lanspery, 1995).

Successful approaches to bring health care and services to residential environments are recognized by the growth in assisted living arrangements for the frail elderly. Other creative solutions are shared-housing referral programs where younger housemates provide service and companionship. Continuing-care retirement communities are campus-style developments offering a variety of housing and long-term services for residents. Many communities have extensive health care options so older persons can age in place without having to give up their apartment when their health changes (Boone, 1993). In Chicago, the nations first intergenerational

community house for independent and assisted-living seniors, reserves seven apartments for younger people, some of whom will receive free room and board in exchange for helping their neighbors (Hinz, 1994).

Senior housing providers will be impacted in a managed care environment. Housing with coordinated, supportive services will be attractive to managed care organizations, such as hospital networks. Services can be co-located and will act as an entry point by managed care contractors for healthy consumers in need of services. The healthy, but aging consumer is also interested in housing with supportive services as a first choice rather than funneling private funds toward nursing facilities if the need arises (Managed Care, 1994)

Assisted Living

Enormous attention is being given in academic, political and practice settings to the burgeoning cost of care, consumers expectation for a variety of alternatives to nursing home placement, and the growing recognition that services should not be separated from housing. The growth in assisted living is in response to concerns for needed long term care options. It is a reconceptualization of long-term-care services for special-needs populations including the frail, cognitively impaired, and physically disabled older adult. It offers an enhancement of care service capacity, and a shift in values about how care is provided. Assisted living supports the normalization of the environment which enhances independence, offers observation,

assessment, care planning, early intervention and referral to appropriate providers. It empowers the frail and impaired older adult, and embraces the concepts of shared responsibility, bounded choice, and shared risk (Wilson, 1994).

In response to needs for more cost effective, long-term care options, assisted living has grown dramatically. It is seen as a humane model for housing residents who do not require 24-hour attention for physical or cognitive impairments, but need assistance with personal care and ADL tasks. Individual apartments with congregate meals, scheduled activities, medication assistance, and supervision are provided, as well as housekeeping, and laundry. Access to health care is available for specific residents by contracting with home health agencies, physicians, therapists and other health specialists. Most residents in assisted living facilities are private, although many states are exploring options for Medicare and Medicaid waivers as cost effective means of managing care (Hooyman and Kiyak, 1996)

Assisted living is not federally regulated, but state regulatory activity is on the rise. The American Association of Home and Services for the Aging (AAHSA) released its position on Assisted Living in 1995, calling for "any existing or future form of regulatory oversight to avoid prescriptive, institutional standards ... emphatically encouraging policymakers and regulators to use outcome based standards...when developing standards" (Gulyas, 1996). In 1996, thirty-one states had policies concerning assisted living, fifteen states have already

regulated assisted living, and nine states are developing regulations. Twenty-two states reimburse or plan to reimburse assisted living facilities as a Medicaid service (Mollica, 1997).

Extensive discussion of linkages between managed care and assisted living have been spawned by the simultaneous growth of enrollment in Medicare managed care plans and assisted living facilities throughout the United States. Interest among state policymakers in capitated long-term care Medicaid programs has also stimulated the potential for the development of links between managed Medicaid and assisted living. There are three potential relationships between a health maintenance organization and an assisted living facility:

> First, facilities can be part of an HMO network that manages the delivery of services. Second, HMOs may consider reimbursing for services in assisted living facilities as a substitution for Medicare covered services. Third, HMOs may reimburse assisted living as a service covered by Medicaid managed care programs that include long-term care services (Mollica, p. 997).

Assisted living is considered a less costly alternative to nursing home care. The older adult living in an assisted living facility can receive services and limited supervision. Physical therapy or skilled nursing services can be provided without entering a skilled nursing facility. In this example, a medicare risk patient can receive services paid by the managed care organization without the responsibility for both room and board and health services (Managed Care, 1994).

As a potential provider or setting for the provisions of services covered by managed care plans, assisted living facilities will demonstrate that residents have fewer hospitalizations and skilled nursing stays through improved medication management and other facility services, such as a safe, supportive environment, and nutritious and supervised meals. Facilities also serve as a setting in which HMO covered home care can be delivered in a more cost effective manner than driving across towns or counties to provide the service (Mollica, 1997).

Networks are combining assisted living, nursing facilities and home health agencies as a strategy to offer HMOs a broad range of service. Assisted living facilities with outpatient day health centers, outpatient rehabilitation services, physician offices and clinics, short stay (respite services), and wellness center are open to residents and to the community. Such facilities offer services at a lower cost, reduce "spend down" for future Medicaid residents, offer expanded coverage under long term care insurance policies, and produce cost savings from delivering home health services in a more structured and supervised setting (Mollica, 1997).

Adult Day Care

Adult day care is vital to the long-term care continuum as a community-based service which identifies the patient's needs by assessment, and meets the needs with an individualized, interdisciplinary care plan. The disciplines involved include social services, health services, social services,

activities, and therapies. Adult day care or day health allows the patient to remain in the community, and enables respite and work time for the family caregivers. The average participant is 73 years old (American Association of Homes and Services for the Aging, 1992).

Fifty percent of participants need some supervision, while 20 percent require constant supervision. Eight percent are incontinent, ten percent are developmentally disabled, and eight percent are behaviorally disruptive. Adult day care is privately and publicly funded. Licensed adult day health centers exist as free-standing community programs, or in continuing care retirement communities, nursing homes, assisted living facilities, and hospitals (American Association of Homes and Services for the Aging, 1992). In existing facilities across the country, 93% provide recreational therapy and activities, 90% offer social services, 81% provide transportation, 77% have nursing services, 60% offer rehabilitation services, 56% pass medications, and 80% provide personal services such as bathing. Licensure is required in 25 states (Eli's Home Health Care Report,1995).

According to Cox and Reifler (1994), adult day centers are becoming a practical and appealing answer to long term care needs. Communities of 20,000 or smaller can support adult day care centers with a potential for 20-30 participants per day. The day center can be dementia-specific, or care for a combination of adults requiring assistance for chronic mental illness, chronic physical functional disorders, AIDS, multiple

sclerosis, and others. Respite services, overnight options, in-home care, and ancillary services are common. With an average start up time of two to thee years, the cost is estimated to be between $200,000 and $300,000 per year. Reimbursement is covered privately or by private insurance, government assistance and grant dollars. A four year demonstration project, funded by the Robert Wood Johnson Foundation, showed that adult day care centers can effectively care for people with dementia; a demand for the service exists; and families are willing to pay out of their own pockets.

Although traditional day care facilities have focused on providing a safe environment with socialization opportunities, managed care pressures are leading toward the development of a niche market for higher acuity patients. As managed care markets mature and are penetrated with managed Medicare and Medicaid beneficiaries, home care providers and adult day care facilities will develop synergies to meet the demand for quality care in a cost effective manner. Capitan, co-chairman of the National Institute on Adult Daycare's public policy committee and a professor at Brandeis University, notes that day care is evolving into programs which treat more complex cases that need on-going supervision. This is occurring because it is more cost effective to treat in the day facility rather than home. An example would be infusion therapy (Eli's Home Health Care Report, 1995).

Transportation

Gelfand (1993) explains that transportation programs are necessary to support community-based services such as adult day care. Transportation programs are crucial for the older adult to be able to access programs, medical care and maintain relationships with family and other support systems. It is necessary for programs to stay abreast of all transport services and be open to creative solutions. Tracy finds that transportation, a costly and necessary issue for each facet of health care for the elderly, may be coordinated on a collaborative basis with other community providers. For example, to provide transportation to an adult day care center, a handicapped accessible van owned by the sponsoring nursing home was utilized. Service was augmented by a local wheelchair transportation company. Eventually, all transportation was shifted to a transportation company. An economic analysis determined that it was equally cost-effective to contract with an external transport company as to provide transportation.

Parish Health Ministy

Churches and faith congregations bring wellness to the the community. Congregations are partnering with the hospitals and long term care facilities to meet the holistic care needs of the older adult. Pastors, clergy, deacons, parish nurses, and volunteers are working with a large population of older adult members living at or making a rapid return to their home following a short term stay in the hospital or sub-acute

facility. Parish or congregational nurses create the link between medicine and religion as they establish relationships that mend physical, psychological, and spiritual brokenness. "They provide an intentional ministry focused on prevention of physical or spiritual impairment and assistance in restoring one's balance of body, mind, and spirit" (Wood, 1992, p. 5).

The parish health ministry, an emerging concept, is growing rapidly as congregations and medicine are turning to parish nurses to provide holistic care in the community. According to McDermott and Burke (1993, p. 186), " The populations currently served are those interested in high-level wellness, the chronically ill, and the high percentage of adults over 55 years of age." The parish nurse serves as personal health counselor, health educator, referral source and liaison to community resources. She/he serves as coordinator of volunteers and support groups and as an interpreter of the close relationship between faith and health. Twenty percent of the parish nurse time is spent counseling, 14% teaching, and 6% facilitating volunteers and support groups.

Churches are stable institutions in neighborhoods and they act as classrooms, kitchens, and meeting areas. They are places where people ask for help and get support. Wellness sessions, transportation services, respite assistance, health screenings, adult day care, educational services, volunteer training programs, support groups, and other services can be offered in churches in collaboration with the health care community. This collaboration offers invaluable awards in the

continuum of care with little expense to either partner, the church or the health network (The Catholic Health Association, 1992).

An example of a collaborative effort was Lloyd's, et. al., (1994) study which covered a "train-the-trainer" model for health education developed for African-American lay representatives (health ministers) from churches in Northeast Tennessee. The lay trainers were taught by East Tennessee State University faculty affiliated with the Center for Geriatrics and Gerontology and the Ohio Valley Appalachian Regional Geriatric Education Center. The 56 hour program was given to health ministers who were natural caregivers and ideal candidates to provide a bridge between the informal and formal health care systems. They were responsible to carry on the mission within their assigned churches. The content covered aging issues, health promotion, and disease prevention for aging African Americans. Workshops included group discussions, games, simulations, and audiovisual presentations. Positive outcomes were noted which increased networking, created formal linkage within the community, and created new resources for health promotion and disease prevention activities.

Health Education

Health education is an intervention which can impact health behavior, improve the quality of life for the older person and caregiver, assist in the informal and self-management of chronic illness, prevent or delay acute illness

and subsequent hospitalization or institutionalization, reduce health care cost, and support and guide patients and families as they transition through the continuum of health care services. Our aging society can benefit from group educational programs addressing the holistic needs of older adults and the informal network of community-based caregivers.

A program for health education of the elderly and their caregivers is necessary to provide early access to appropriate providers, reduce limited or fragmented use of health care options, and improve outcomes for the frail elderly. It can be provided in groups within the community, in a primary care setting, senior centers, retirement communities, adult day care, churches, extended care and sub-acute facilities. Allied health professionals and para-professionals, lay volunteers, peers coping with chronic conditions, and others interested in health promotion, prevention and care management. Topics will vary depending on the needs and interest of the older adults, and the skill level of the teacher/facilitator. Community-based class or meeting agendas can cover, but are not limited to: exercise and fitness, pain management and relaxation, depression, nutrition, fatigue, problem solving, doctor-patient relationships, medications, common self-management tasks, legal and financial assistance.

The need for information and support is also a focus of the in-patient population. In a study by Gerteis, et. al., (1993) discharged patients and their families, physicians, and non-physician staff defined the need for information, education,

emotional support, involvement of family, and continuity during the transition process as primary dimensions of patient centered care.

Johnson (1995) finds the caregiver needs to fall into two categories: information and support. Information is needed to develop an understanding of the aging person's needs and their own needs. The information is necessary so they can give the best care possible while enabling them to retain their own integrity, sense of self, identity, and not become overwhelmed by the burden of care. Support is needed to know that others care about them and their caregiving role. Support can sustain caregivers by offering a forum for sharing and providing opportunities to learn how others deal with the struggle they must endure.

A psychoeducational model which helps older people and their family become more knowledgeable and involved in self care is described by Pugh, et. al., (1994). Psychoeducational programs empower the older person and caregiver by providing information about health concerns and encouraging strategies to help themselves remain healthy and functional. It transfers the task of care management from formal service providers to the older people themselves. This strategy also addresses the increasing labor force shortage. A multidimensional approach incorporates three health domains which aid in reaching the goal of translating information to behavior. The three domains are cognition, affect, and resources.

Weinrich, et. al., (1989) identify common physiological and psychological changes with aging which may have an affect on the older persons ability to learn. These should be taken into consideration when planning an educational program. For example, hearing and eyesight may be impaired, so it is necessary for the educator/facilitator to speak distinctly in a normal or low pitch voice; face the learners; decrease extraneous noise; reinforce verbal teaching with pictures, or models; and use large print materials. Care should be taken to account for the ability of older adults to learn and remember. Effective strategies include: slowing the pace; repeating often; using audio-visual and written materials; using illustrations; and decreasing outside stimuli. Because sociological and psychological factors affect learning, the educational level, experience in an educational setting, and mental status of the older adult learner may necessitate adaptions in materials and programs.

Adapting and evaluating teaching tools is recommended by Weinrich and Boyd, (1992) because older adults developmental stage, life-style habits, role changes, losses, and change in body image influences their response to the teaching tools utilized. Not only should they accommodate normal aging changes, but they need to offer a benefit. The material should portray a positive psychological tone, and emphasize that aging can be a happy and healthy time of life. The reading level should be seventh grade or less. The language should be clear, simple, and concrete. Teaching tools may include written

materials, displays on the chalkboard or bulletin board, and audiovisual material. The information presented must be accurate, appropriate, instructional, nonthreatening, optimistic, honest, and able to meet the behavioral objectives and developmental needs of the older person and the caregiver.

Chapter III

Method

The researcher utilized experience as an administrator of a 120 bed sub-acute and long term care facility, participant in system-wide strategic planning task force, member of long term care groups and associations, advocate for aging services at the state and local level, leader in collaborative community projects serving the frail elderly, and graduate student at Lindenwood college to research the topic of long term health care for older adults. The author had the opportunity to attend conferences and meetings related to the subject, request research data, and use the extensive services of a teaching hospital medical library. Upon conducting a thorough literature search, the findings were reviewed with gerontologists, geriatricians, interdisciplinary clinicians, planners, managed care, fiscal, and administrative professionals.

Based on the findings and personal insight, this author described a method for determining the healthcare needs of older adults and the resources within a health delivery network and community. A vision and proposal for integrating a seamless continuum of care which incorporates acute and primary care with long term care and services is described and illustrated.

This thesis has been incorportated into a strategic business plan for long term care in a health delivery network.

Chapter 4

Proposal

The Vertical Integration of Long Term Care in an Integrated Delivery Network

A traditional Integrated Delivery System horizontally unites acute care, primary and speciality physician services, and insurance capabilities. However, a major component to a seamless continuum of care is the vertical integration of long term care and services into the health delivery network. The inclusion of subacute, skilled, home-care and community based long term care services are vital to the mission of serving persons, families and communities.

A vision for integrating long term care services into a traditional health delivery system of acute and primary care is proposed. Normal aging marked by fairly good health, the frailty that is common among the elderly, and the emerging needs of the chronically ill and disabled people of all ages are considered. Pertinents factors and assumptions are listed. Common elements of the continuum are outlined. A planning and visioning process which precedes the vertical integration of long term care into the health delivery network is described. A proposal for a holistic, mission-inspired programs in a transformed health delivery system is offered.

An analysis of the strengths, weaknesses, opportunities and threats within the system and community could begin by listing demographic, social, and socioeconomic factors which may impact the vision and plan. Attributions are included.

Demographic Attributions

1. The fastest growing segment of the population is older adults.

2. The likelihood of developing multiple, chronic, and disabling impairments and illness increases with age.

3. Nearly one-half of the over 85 year population will develop Alzheimer's disease.

4. The financially deprived and oldest-old have a rapidly increasing need for personal health care and are high users of health services.

5. The need for long term care facilities to serve those over 65 will increase dramatically.

6. Families provide nearly 80% of the in-home care for relatives with chronic illness.

7. Over 85% of the population are uninsured for long term care.

Social Attributions

1. Services provided should assist and enable the older adult to achieve his/her maximum potential for independence, functional capacity, spiritual growth, and autonomy in the least restrictive environment.

2. Aging in place phenomena will create a need for long term care services and living arrangements which will accommodate impairments and limitations.

3. The holistic health needs of the older adult require interdisciplinary care management through a wide spectrum of health and social and long term care services which enables the

older adult to remain as independent as possible for as long as possible.

4. Transportation is essential so elderly can access services.

5. Local churches can provide a major link of the older adult to the health care community. Health education, counseling, early interventions and referrals to appropriate health resources can be coordinated through a congregational ministry.

6. Volunteers who are trained to care for older adults will be vital when professional or family support is limited.

7. A collaborative alliance among many providers, agencies, and organizations is necessary to meet the many complex needs of the older adult and caregivers.

Socioeconomic Attributions

1. Caregiver stress creates health problems in the caregiver.

2. As more women enter the work force, there will be fewer informal caregivers while the need for care will increase.

3. Worker productivity will be reduced as caregiving responsibilities increase.

4. Eldercare programs assist caregivers manage the long term decline in functional and health status of older adults, and businesses maintain productivity.

4. Reimbursement systems will continue to be retooled under entitlement programs.

5. Managed care organizations will require more home-based, hospice, adult day care, assisted living, and housing with coordinated services arrangements to manage the conditions and costs of the older adult.

6. Emphasizing cost-efficient behavior with heath promotion and prevention programs encourages maintenance of health and functional status in the older adult.

7. There is a market niche for long term care insurance. which creates a private market for long term care services in the future.

8. Adult day care, housing and assisted living are a major, cost effective component of long term care vital to resisting hospitalization and institutionalization.

9. Coordinated, supportive services in residential arrangements are attractive to managed care organizations, policy makers and the private sector.

10. It is less costly to provide health and social services in adult day health centers or residential arrangements than travel to individual homes across cities and counties.

Common Elements in Vertical Integration

Each delivery system is unique, and the vertical integration of a continuum of long term care services must be developed to meet the needs of the person, family, and community the health system serves. However, common elements include:

1. The development of a continuum based on community needs and program assessments in collaboration with health,

housing, social service, mental health, recreational, educational institutions, governmental agencies, and local churches.

2. The provision of a wide spectrum of programs which may include, but not be limited to: outreach programs, health education programs for older adults and caregivers, nursing homes, assisted living, housing with services, personal assistance, senior ambulatory clinics, hospice, health promotion and prevention programs, adult day care programs, sub-acute care, home health,parish health ministry and volunteer programs, and geriatric assessment.

3. Information systems and extended care paths which are utilized throughout the system.

4. A system of care management system, case management, and service coordination incorporating an interdisciplinary and holistic approach to person centered care and services.

4. The development of programs which involve, assist, and support the family and caregiver.

5. The provision of excellence in service and quality management. Indicators of quality programs and services are monitored and evaluated with a goal of continuously improving services and improving costs.

6. The ability and willingness to serve as leaders, advocates, and participants in a variety of roles, alliances, and partnerships with organizations, agencies, institutions, associations, and individuals serving the older adult and chronically ill person.

Community Needs and Resources Assessment

A Long Term Care Planning Task Force should be formed. The task force must assume a community planning perspective. The group should include system planners, acute and long term care representatives from within the system, social services professionals, physicians, managed care and fiscal analysts, and older adults. The members of the task force collect data and information, determine a vision, and develop a business plan to integrate a seamless continuum of long term care services into the acute and primary care health system.

The task force collects demographic information on older adults and caregivers in the community. The needs and priorities of older adults and caregivers, inventory of long term care facilities, programs and services are included. Selected county census projections, social and economic characteristics of older adults, disability status of non-institutionalized persons, and ethnicity information are collected. Health facility utilization, discharge and cost data are compiled. Information pertaining to waiting lists, payor and referral sources are garnered. The cost of services, payors and future reimbursement trends are analyzed.

Sources to contact for community needs assessment data include the Area Agency on Aging, Division of Aging, educational institutions, the public health department, catholic charities, the catholic archdiocese or other religious affiliated institutions, and the United Way. Associations associated with the older population or the long term care industry, such as the

American Association of Homes and Services, American Health Care Association, or American Hospital Association can provide information.

A resource inventory of programs and services offered within the health system,as well as the community at large is necessary to identify unmet needs and gaps in services. The inventory of institutional services includes sub-acute beds, long term care facilities, assisted living, residential care, congregate care facilities, and other programs. The assessment should include admissions, payor source, age categories, length of stay, percent of occupancy, referral sources, strengths and weaknesses, volume, and market share.

An inventory of community services and programs is necessary to assess the location, the market utilizing the service, the sponsor's resources and interest in forming and alliance, the units of service, reimbursement and payor source, profitability, number of clients, and the cost. Table 3 includes a checklist of community services which should be inventoried.

Market Dynamics

As the task force continues to clarify community needs and resources, it is critical to understand the level of managed care penetration in the community. Are managed care organizations enrolling Medicare/ Medicaid beneficiaries? Is the state attempting to increase Medicaid managed care? Have Medicaid/ Medicare waivers been approved within the state? Is there a PACE Program or demonstration site in the area?

Are businesses encouraging retirees to enroll in Medicare risk programs? Is the managed care census in sub-acute beds increasing? Is there a private market for housing, assisted living, and long term care insurance? Is the business community open to eldercare programs?

The business community and individuals are interviewed to determine if there is interest in long term care insurance. The impact of caregiving on productivity in local business is analyzed. An inventory of eldercare programs is assessed.

Table 3
Long term care community service and program inventory checklist

Care management	Skilled nursing facilities
Case management	Information/referral
Adult day care	Volunteer training
Personal care	Senior clinics
Home health	Chore services
Delivered meals	Telephone reassurance
Respite care	Emergency response
Service coordination	Caregiver support
Parish ministries	Shopping assistance
Group education	Congregate meals
Health promotion	Pharmacy coordination
Prevention programs	Senior centers
Transportation	Housing
Shopping assistance	Friendly visiting
Senior centers	Telephone reassurance
Financial services	Dental services
Senior volunteers	Respite care
Counseling	Caregiver counseling
Geriatric assessments	Eldercare programs
Dementia programs	Assisted living facilities

Sharing the Vision

The gaps within the organization and community are recognized. It is time to create the vision, which is based on the overall mission and values of the organization, and begin transitioning into a fully integrated system. The leadership team should identify goals, begin to share ideas, motivate the organization and potential alliances within the community. Clearly defining and educating the board and management is critical. The process of network building, aligning with organizations, practitioners, and payers in new and different ways marks the beginning of the transformation into a vertically integrated system.

When partnering with long term care organizations, agencies and programs, it is important that the mission and values must be compatible, services complementary, and costs of providing the service realistically achievable. The alliances formed must be logistically feasible, congruent, in management styles, and financially strong. The new relationships will require clarity of purpose, and desired outcomes for all concerned, and a clear definition of characteristic of the ministry. Physical plant, accreditations, survey findings, and other regulatory issues must be considered.

Health System Characteristics

As the vertical integration of long term care into the seamless continuum begin, there is a given potential to improve care, control costs, and improve competitive position of participating providers. It is assumed that the health

system envisioning the integration of long term care into the continuum will have the following characteristics:

1. There is common management and coordination of services throughout the health system.

2. The health system enters into contracts with health plans, and owns a health plan with a managed care component for seniors.

3. The system includes hospitals, sub-acute beds , long term nursing homes, and primary care locations to provide geographic coverage within the service area.

4. Information systems are available to provide communication ability to components.

5. The system has the capital needed to expand the continuum.

6. A Quality Management Program monitors quality and outcomes.

7. A system for identifying costs is available to each service areas.

Long Term Care Characteristics

It will be assumed that the long term care organization which will be integrated into the continuum will bring the following expertise in caring for the older adult:

1. A focus on maximizing the older adult's potential for acheiving activities instrumental activities of daily living in order to be as independent as possible for as long as possible.

2. An understanding of regulatory issues, and a demonstrated ability to comply with quality monitors and

quality indicators for care of the older adults. The indicators include, but will not be limited to: skin integrity, nutrition and hydration, chemical and physical restraints use and falls, polypharmacy, mental status and depression, readmissions, discharge disposition and functional capacity.

3. The experience of interdisciplinary care management necessary to address the holistic care needs of the older adult and caregiver.

The Long Term Care Continuum

The continuum of services for older adults and chronically ill or disabled persons, encompasses a kaleidoscope of programs, services, and products which cross-cut nearly every service in a health system. Incorporating programs and services to meet the long term needs of the older adult will offer Medicare centers of excellence, such as cardiology, surgery, orthopedics, and oncology an opportunity to improve the quality of care and improved outcomes while effectively controlling costs. The long term care continuum and model programs for integrated delivery networks are described. Table 4 lists the continuum of services and programs which may serve older adults, families and caregivers.

Table 4

A continuum of older adult programs and services in an integrated delivery system

1. Acute inpatient service
   - Geriatric unit with interdisciplinary assessment
   - Hospice unit
   - Gero-psych unit
   - Acute rehabilitation
   - Caregiver consultation

2. Ambulatory Services
   - Geriatric assessment/consultation
   - Day hospital
   - Out-pt rehabilitation
   - Adult day care-social/medical model
   - Gero-psych clinic & counseling
   - Senior satellite clinic with ancillary services
   - Specialized dementia unit
   - Alcohol & substance abuse
   - Primary care physician offices
   - Incontinence programs

3. Home Care
   - Home health-medicare
   - Home health-private
   - Hospice
   - Home safety and repair
   - Home visitors
   - Home delivered meals
   - Caregiver service
   - Respite programs
   - Parish ministry volunteers
   - Home infusion
   - Durable medical treatment
   - Homemaker and personal care
   - Chore services

4. Extended Care
   - Sub-acute hospital-base units
   - Community-based Skilled Nursing
   - Nursing home physician services
   - Hospice
   - Residential care
   - Respite care
   - Specialized Dementia Units

5. Housing with service coordination
   - Independent senior housing
   - Continuing care communities
   - Assisted living
   - Congregate living

Low-income housing
Short-term housing
Foster home programs

6. Outreach/linkage programs
   - Physician referral
   - Emergency response
   - Transportation
   - Friendly visitors
   - Telephone reassurance
   - Mobile interdisciplinary clinics
   - Mobile clinicians
   - Home delivered meals
   - Congregate meals
   - Older adult/caregiver education
   - Older adult/caregiver support
   - Community Care Management
   - Senior membership programs
   - Volunteer training
   - Parish health ministries
   - Parish nurse training and support
   - Corporate Eldercare Programs

7. Wellness and Health promotion
   - Wellness for seniors
   - Fitness and exercise classes
   - Nutrition classes
   - Screenings
   - Parish health fairs
   - Pharmacy consultation
   - Group education for seniors

8. Financial and insurance mechanisms
   - LTC insurance product
   - Senior HMO

9. Special Senior Support
   - Advocacy
   - LTC Consultation/ education for LTC providers

10. Capitated programs
    - PACE
    - Other waiver programs

Model Programs

Model programs and services are described to inspire acute and primary care leaders to envision a plan for improving quality and reducing costs by integrating long term care for the chronically ill and frail elderly into the health delivery network.

1. At an assisted living facility, independent retirement complex, adult day center, or church, a monthly group health education program is scheduled. Topics include heart disease, chronic pain, pharmaceuticals, cholesterol management, allergies, living will and advance directives, how and when to use the ER.

The agenda includes a lecture taught by Geriatric nurse or social worker with periodic lectures by pharmacist, nutritionist or therapist. Time is allotted for blood pressure screenings, immunization status review, and medication review. Questions are answered, and follow up recommendations are identified. The group is encouraged to have an interactive discussion on clinical lectures, and to plan the topic for next month. Finally the participants can then socialize and exchange information with peers.

2. At senior centers staffed by a geriatrician or internist with geriatric expertise, geriatric nurse practitioners, social worker or RN case manager, nutritionist, and visiting specialists, older adults receive primary care and care management services. The hospital receives full-cost reimbursement of operating expenses, and a five year

depreciation schedule for start-up costs. The center is located close to the hospital, accredited under hospital accreditation, shares common ownership, and integrates the senior center clinically.

3. Consulting pharmacists perform drug regimen or brown bag reviews on the older adults as they visit clinics, primary care office, or adult day care. The pharmacist red flags potential problems, such as polypharmacy and immediately consults with the primary care physician. Seniors are flagged for semi-annual follow-up on complex cases. Physician and group education is provided on commonly flagged problems. The cost savings are in reduced adverse drug reaction, falls, and misuse of medications with subsequent reduction of hospital admissions.

4. In the hospital's geriatric assessment clinic, intensive geriatric assessments are performed to develop a full understanding of the patient needs. A prioritized treatment plan is developed, and frequent reviews and patient evaluations are made to coordinate medical and social interventions.

5. Community Care Management is coordinated by an RN and social worker with geriatric expertise who are based outside the hospital. One professional per 40 active cases can manage high intensity patients requiring up to four visits per month. The case manager would coordinate the system and community resources. For low intensity patients, a nurse or social worker could manage 200 cases with monthly or

quarterly phone calls to monitor problems or answer questions. Referrals are received upon discharge from hospitals, sub-acute facilities and nursing homes. The focus is on education, and with attention given to signs of decline and early intervention.

6. A Senior Companion Program trains low-income senior volunteers over 60 to aid an older person in need. The volunteers receive a small stipend, and reimbursement for travel to serve as a companion for four hours per day to an elderly person in need. The extra income helps the volunteer, gives them a sense of purpose, continued personal growth, and the satisfaction of ministering to others. The older adult and/or caregiver receives companionship and assistance in transportation, physician visits, medication delivery, respite or whatever the need may be.

The program is funded by ACTION, a federal volunteer agency. It is a collaborative effort with public and private partnerships. Senior companions are trained by the system's home health agency in partnership with the Alzheimer's Association.

7. A Parish Health Ministry program is jointly sponsored by the health system and churches in the service area. The parish nurses are employees of the hospital and the partnering church which enables participation in the benefits program and educational opportunities of the hospital. The church reimburses the hospital for the nurse salary after a start up period of limited duration.

The hospital trains parish nurses and volunteers who will develop and implement programs for seniors in the congregation. The parish nurse is a grass roots care manager who serves as health counselor, health educator, referral liaison, and facilitator of volunteer programs and services. Health fairs and screenings are jointly sponsored by the hospital, church and health care community at large.

Volunteer pastoral teams visit the sick, facilitate support, educational, and fitness groups. An adult day care program is offered in collaboration with the hospital. In-home respite programs are provided by volunteers who are trained by the hospital.

The individual and family benefit by the programs. Early referrals are made to appropriate resources, and the health system maintains a visible presence in the community.

8. An adult day care center which traditionally focused on a safe environment and social opportunities has increased the acuity levels of patients accepted into the program. In collaboration with home health, the more medically complex patient is able to receive on-going supervision and services more cost-effectively than at home.

The flexibility of allowing treatment through both home care and outpatient rehabilitation delivered at the adult day care can result in savings to the payor. Physical, speech, and occupational therapy, as well as a skilled nursing visit and social work consultation can cost substantially less a week in an adult day care facility than at home. It also allows the

caregiver to work while the older adult is being supervised in the day center.

9. A health network partners with a free-standing adult day care center which serves the needs of persons in early through late stages of Alzheimer's disease and other dementias and the needs of persons with physical challenges that are mentally very alert. The programs is open routinely from 7am to 5:30 pm, but expands the hours from 6:30 am to 6:30 pm upon request. The center operates on Saturday and Sunday for shorter hours. The enrollment has been 90-100 with a daily attendance range of 50-65. The staff to patient ratio ranges from 1: 4 to 1: 6 depending upon the needs of the clients.

The charge is from $48-$53 per day with additional fees for personal care such as giving baths, shampooing hair, providing physician visit escorts, podiatry, and psychosocial counseling or therapy. The payors are 43% private, 40% Medicaid, 11% VA, 2% LTC insurance, 4% MH/MR contract.

10. The needs of the dually eligible frail elderly are met in two PACE programs in a health delivery network. The care of the older adults enrolled in the capitated program is managed by an interdisciplinary team of clinicians . Although the enrollees are certified by the state to be eligible for nursing home placement, this program has saved 15% of the costs of placement while allowing the individual to remain independent. Its hub is a day center where the patient interacts with the team for coordinated monitoring and

interventions. The flare-up of chronic conditions is reduced, and the onset of acute illness is more readily prevented.

The project cost $1.5 to $2 million to cover construction and renovation costs, a feasibility study, and initial operating expenses. Pace made an original investment of $10,000 per enrollee. The revenue for two centers serving 300 patients is $12,000,000.

11. Supportive services are provided at low-income housing site, and retirement communities by the health network in collaboration with community agencies serving the elderly, and churches. The long term care division manages an adult day care which provides health, social, and related support services to residents, caregivers, and the community. The service is funded privately, by Medicaid, Medicare Part B, VA, and by benevolent scholarships. The hospital holds a weekly senior health clinic on site. It is funded by Medicare, Medicaid, and VA.

Local parish ministries provide escort services to the doctor, pick up and deliver medications, offer support and companionship, weekly exercise classes, and monthly blood pressure screenings. Skilled home health, homemaker chore service, and companion services are funded by Medicare, Medicaid, and private sources. Transportation to the grocery store, shopping and recreational activities are available on an OATS bus.

An acute and primary care health delivery network formed a partnership with the church, the area on aging, HUD,

and a long term care corporation to provide a full continuum of senior services on a retirement campus which includes a low-income apartment, two independent living apartments, villa homes, a private pay assisted living facility with 80 apartments, a 200 bed skilled nursing facility with 40 sub-acute beds, a specialized dementia unit, a senior center, home health agency, and adult day center, primary care senior clinic, community care management, and a child care center for intergenerational programs.

12. A health system offers a senior HMO and long term care insurance to the corporate and business community, retirees, and individuals. Eldercare programs including adult day health, care management, caregiver counseling and support, and educational programs. The program enhances productivity for the workers, serves as an entry point for enrollees, manages care, promotes healthier living for the caregiver and the older adult, and provides a private market for long term care programs.

13. A health system has integrated geriatric care into the network for a holistic approach to health and healthcare. In order to meet consumer needs, it has successfully integrated 13 medical centers, 6 long term care facilities, 7 sub-acute units, 6 regional home health agencies, 3 community/senior center health clinics, 2 assisted living facilities, 2 adult day centers, 2 geriatric assessment clinics, and 4 PACE sites. It has partnered with providers throughout the continuum to develop extended care paths to be utilized at each level of care. It promotes care

management and service coordination to reduce fragmentation and improve access. It considers long term care to be of vital importance in meeting the mission of providing service to persons, families, and communities.

Proposed Vision

A person-centered kaleidoscope of acute, primary and long term care and services for the older adult and caregiver in a integrated delivery system is proposed. It is illustrated in Figure 5. This vision for aging promotes a holistic approach to person centered care for the older adult. It includes a comprehensive set of services, ranging from preventive and ambulatory care to acute or rehabilitative and extended care. It includes community-based social support for the older person and caregiver. It is a kaleidoscope of services which requires multiple providers from long term care, acute and primary care, and community-based agencies and organizations to work collaboratively and cooperatively. It demands a person centered approach to compassionate and skilled care for the older adult and caregiver.

A holistic pursuit of care management is woven throughout the continuum by interdisciplinary teams of clinicians and staff who are advocates for aging and the frail elderly. Service coordination, information systems, and extended care paths enable a smooth transition as the patient and caregiver traverse the maze of health and social services. Quality management assures the goals of providing cost-

effective care with improved quality, outcomes, and satisfaction.

It is the recommendation of this author that the proposal, which reduces fragmentation, confusion, and difficult access to services, be considered by health networks for vertical integration into a delivery system. It can provide a seamless continuum of cost effective quality care to persons, families, and communities in a managed care environment while encouraging the possibility of long term cost control for the nation.

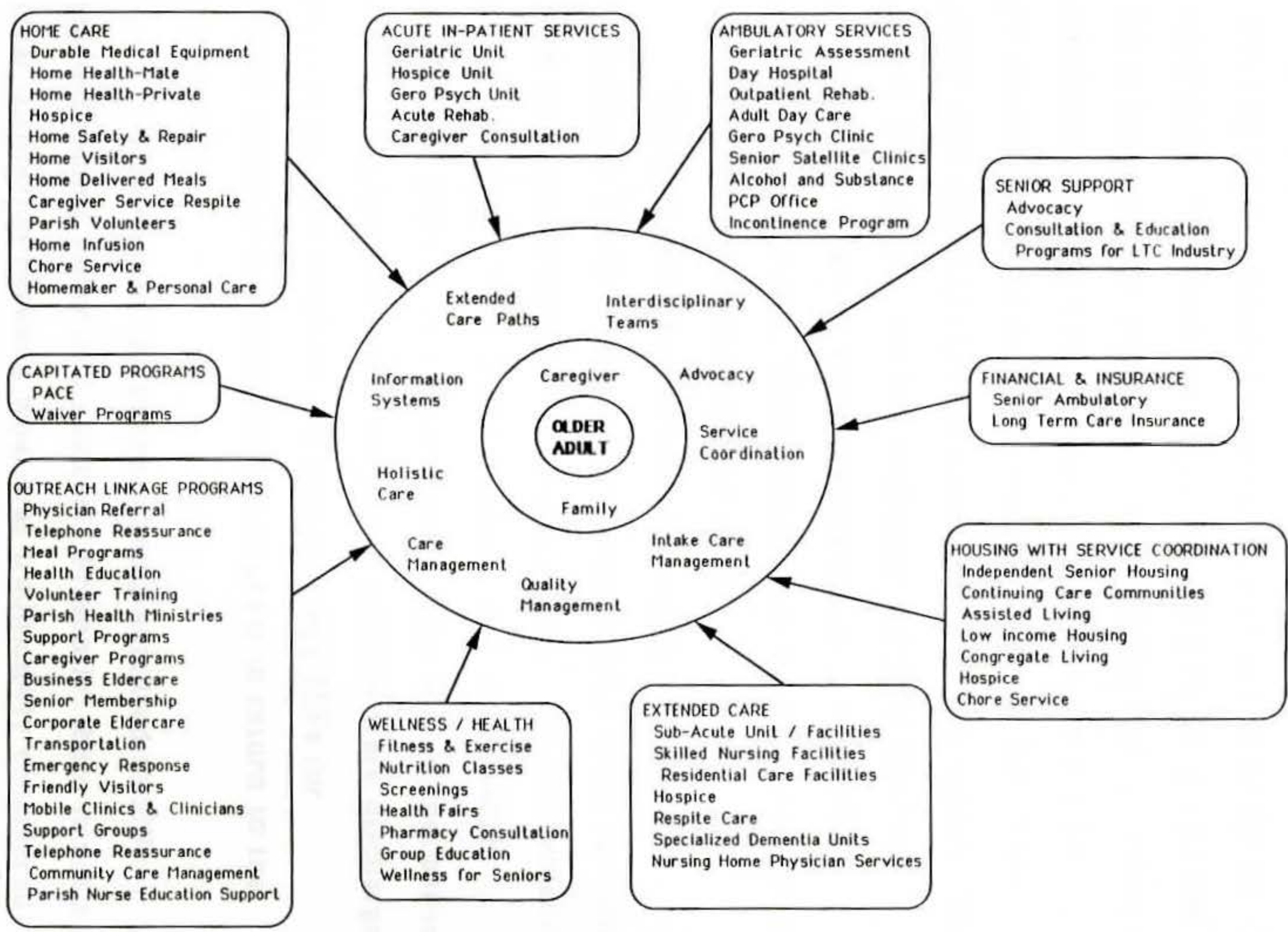

Figure 2. A person centered kaleidoscope of care for the older adult and caregiver in an integrated delivery network.

Chapter V

Discussion

Several factors have encouraged the trend toward integrating acute and long term services. Society is concerned over this nations ability to provide basic health care for all Americans. The ability to support entitlement programs for the growing elderly population has encouraged the retooling of reimbursement systems. Economic pressures created by government and the corporate community have forced the health care industry to reduce costs and improve quality. The growth of managed care has fueled the need for creating collaborative alliances and networks which offer the full continuum of services. The focus in healthcare has changed to a wellness rather than an illness model.

The past two decades have witnessed a dramatic evolution in healthcare for older adults. Fifteen years ago, long term care was synomous with nursing home. Patients entering nursing facilities were called residents, and were seldom discharged home or to a lower level of care. Within the last ten years, a limited number of non-acute patients were discharged from acute care hospitals and admitted into SNFs for rehabilitation and medical treatment prior to return to the community.

Five years ago, the patients being admitted to SNFs started coming sicker and quicker. Presently, there is not a clear distinction between what was traditionally considered acute care, and what is now termed sub-acute care. However,

reimbursement is less. Patients receive sub-acute and skilled care in a SNF, and return to the community or an extended care facility which encourages independence, and is a less costly alternative to nursing home care.

Clearly two distinct and separate industries existed until DRGs and managed care encouraged the development of less costly alternatives. The Health Care Financing Administration created financial incentives for hospitals to discharge patients earlier and quicker than when they were reimbursed at cost. In the early years of prospective payment, patients were to sick to be discharged to unsophisticated SNFs who were ill-equipped, staffed or trained to provide care for the high acuity patient so they remained in the hospital. It was not long, however, before the hospital industry realized they could discharge an acute care patient under a DRG to a hospital-based SNF unit or facility, and be reimbursed at cost for routine and ancillary services.

As managed care enters the market, the added incentive to move the patient out of an expensive acute facility into a less costly area creates a market that both the long term and acute care industry want to reach. Hospitals have clinicians and staff well equipped to provide high tech care, but may lack an understanding of highly regulated long term care standards and the need for comprehensive care required by the frail elderly. The long term care industry understand the needs of the geriatric patient and family, and recognize the absolute necessity of comprehensive, holistic interdisciplinary care, but

may not have the resources or staff prepared to deliver care to the higher acuity patient being discharged from the hospital.

As managed Medicare and Medicaid plans scramble for lower cost providers, and HCFA prepares to roll out prospective payment for SNF providers, it behooves the long term and the acute care industry to collaborate rather than compete. As each industry attempts to diversfy in order to meet the needs of a burgeoning population, carry out their respective mission to the older adult and frail elderly, and create a niche in the marketplace to assure continued viability, it becomes apparent that healthcare and society would benefit from mutual and cooperative efforts of the two industries coming together to form an alliance and partnership of service.

This thesis considers the marriage of two great industries to unite their unique resources and alternatives in a seamless continuum to meet the needs of older adults who must transition through levels of acute, sub-acute and extended or community-based care. The time is ripe to invest in and foster the best in both industries to improve care, maximize functional independence, assist caregivers, promote health, prevent acute episodes of chronic illness, and create new alternatives to meet the needs of the patient and caregiver. The vertical integration of hospitals, nursing homes, and community-based services for the older adult and chronically ill individual can benefit each industry, the individual, the family, and the nation.

This thesis is a culmination of extensive research and years of experience in both the long term and the acute care industries. Experience led the author to believe this vision for aging was possible, and research has confirmed that integration is necessary and probable. The vision for aging presented in this thesis is timely, realistic and achievable.

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