DOWNLOAD PDF SUCCESSFUL MODELS OF COMMUNITY LONG TERM CARE SERVICES FOR THE ELDERLY

Chapter 1 : Fully integrated care for frail elderly: two American models

Chapters focus on policies for the development of effective models, from the perspectives of municipal, county, state, and federal governments involved in community service provision, and the role of colleges and universities in training personnel to develop and implement community-based long term care services.

Facilities that offer formal LTC services typically provide living accommodation for people who require on-site delivery of around-the-clock supervised care, including professional health services, personal care, and services such as meals, laundry and housekeeping. While the US government has been asked by the LTC long-term care industry not to bundle health, personal care, and services e. Greater success has been achieved in areas such as supported housing which may still utilize older housing complexes or buildings, or may have been part of new federal-state initiatives in the s. These services are usually ordered by a physician or other professional. Depending on the country and nature of the health and social care system, some of the costs of these services may be covered by health insurance or long-term care insurance. Modernized forms of long term services and supports LTSS , reimbursable by the government, are user-directed personal services, family-directed options, independent living services, benefits counseling, mental health companion services, family education, and even self-advocacy and employment, among others. In home services can be provided by personnel other than nurses and therapists, who do not install lifts, and belong to the long-term services and supports LTSS systems of the US. Informal long-term home care is care and support provided by family members, friends and other unpaid volunteers. Long-term services and supports[edit] "Long-term services and supports" LTSS is the modernized term for community services, which may obtain health care financing e. Congress, has indicated that while hospitals offer acute care, many non-acute, long-term services are provided to assist individuals to live and participate in the community. An example is the group home international emblem of community living and deinstitutionalization, [11] and the variety of supportive services e. Long term services and supports are discussed in depth in the forthcoming, Public Administration and Disability: Community Services Administration in the US Racino, manuscript , in press, [15] The new US Support Workforce includes the Direct Support Professional, which is largely non-profit or for-profit, and the governmental workforces, often unionized, in the communities in US states. The direct care workforce envisioned by the MDs physicians, prepared by a medical school, subsequently licensed for practice in America who did not develop the community service systems, and serve different, valued roles within it were described in as: The original state departments were Intellectual and Developmental Disabilities, Offices of Mental Health, [32] lead designations in Departments of Health in brain injury for communities, [33] and then, Alcohol and Substance Abuse dedicated state agencies. Among the government and Executive initiatives were the development of supportive living internationally, [34] [35] new models in supportive housing or even more sophisticated housing and health , [36] and creative plans permeating the literature on independent living, user-directed categories approved by US Centers for Medicaid and Medicare , expansion of home services and family support, and assisted living facilities for the aging groups. Needs for long-term care[edit] Nurse at a nursing home in Norway Life expectancy is going up in most countries, meaning more people are living longer and entering an age when they may need care. Meanwhile, birth rates are generally falling. Globally, 70 percent of all older people now live in low or middle-income countries. These factors often contribute to an increased need for paid care. Estimates from the OECD of these figures often are in the 80 to 90 percent range; for example, in Austria , 80 percent of all older citizens. A study by the U. Department of Health and Human Services says that four out of every ten people who reach age 65 will enter a nursing home at some point in their lives. The major argument for the new services was cost savings based upon reduction of institutionalization. The states pay a monthly capitated rate per member to the MCOs that provide comprehensive care and accept the risk of managing total costs. This movement, based in part on feminist trends in the workplace, has intersected with other hospital to home, home health care and visiting nurses,

user-directed services, and even hospice care. Long-term care funding[edit] Governments around the world have responded to growing long-term care needs to different degrees and at different levels. These responses by governments, are based in part, upon a public policy research agenda on long term care which includes special population research, flexible models of services, and managed care models to control escalating costs and high private pay rates. Some countries have had publicly organized funding arrangements in place for many years: Other countries have only recently put in place comprehensive national programs: Some countries Spain and Italy in Southern Europe, Poland and Hungary in Central Europe have not yet established comprehensive national programs, relying on informal caregivers combined with a fragmented mix of formal services that varies in quality and by location. In Finland , informal caregivers received a fixed fee from municipalities as well as pension payments. In the s, a number of countries with social health insurance Austria in , Germany in , Luxembourg in began providing a cash payment to service recipients, who could then use those funds to pay informal caregivers. The scheme covers the care needs of people who as a consequence of illness or disability are unable to live independently for a period of at least six months. These "health care schemes" on the commodification of care were compared to individualised planning and direct funding in the US and Canada. Funding for LTC facilities is governed by the provinces and territories, which varies across the country in terms of the range of services offered and the cost coverage. In the development of home and community-based services, individualised services and supports were popular in both Nations. In contrast, the US initiatives in health care in that period involved the Medicaid waiver authority and health care demonstrations, and the use of state demonstration funds separate from the federal programs. One of these includes out-of-pocket spending, which often becomes exhausted once an individual requires more medical attention throughout the aging process and might need in-home care or be admitted into a nursing home. For many people, out-of-pocket spending for long-term care is a transitional state before eventually needing Medicaid coverage. In addition to personal savings, individuals can also rely on an Individual retirement account , Roth IRA , Pension , Severance package or the funds of family members. These are essentially retirement packages that become available to the individual once certain requirements have been met. Medicaid also fund traditional home health services and is payor of adult day care services. Currently, the US Centers for Medicaid and Medicare also have a user-directed option of services previously part of grey market industry. In the US, Medicaid is a government program that will pay for certain health services and nursing home care for older people once their assets are depleted. In most states, Medicaid also pays for some long-term care services at home and in the community. Eligibility and covered services vary from state to state. Most often, eligibility is based on income and personal resources. Medicare pays only for medically necessary skilled nursing facility or home health care. However, certain conditions must be met for Medicare to pay for even those types of care. The services must be ordered by a doctor and tend to be rehabilatative in nature. Medicare specifically will not pay for custodial and non-skilled care. Medicare will typically cover only skilled nursing days following a 3-day admission to a hospital. A study conducted by AARP found that most Americans are unaware of the costs associated with long-term care and overestimate the amount that government programs such as Medicare will pay. Long-term care insurance protects individuals from asset depletion and includes a range of benefits with varying lengths of time. This type of insurance is designed to protect policyholders from the costs of long-term care services, and policies are determined using an "experience rating" and charge higher premiums for higher-risk individuals who have a greater chance of becoming ill. The New York Times explains how some of the businesses offering long-term care are misusing the loopholes in the newly redesigned New York Medicaid program. For those that are poor and elderly, long term care becomes even more challenging. Often, these individuals are categorized as " dual eligibles " and they qualify for both Medicare and Medicaid. These individuals accounted for

Chapter 2 : The Problem: Caring for Aging Baby Boomers

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Open in a separate window Source: Adapted from Kodner [3]. Each of the models is elaborated on below. Key program components are described first. This is followed by a case presentation depicting the process of care, using a different hypothetical patient for each model. Evaluation results, including findings on quality and cost impacts, are then discussed. Finally, the lessons learned will be briefly summarised. Social health maintenance organisation 11 The Social HMO is a federally funded demonstration project, which combines health and social care, both acute and long term, into a single, care managed delivery system [29 , 31]. The program is targeted primarily to elderly Medicare beneficiaries, and is predicated on the belief that an integrated approach will facilitate more appropriate care and lower costs. The four Social HMO sites are: Targeting The Social HMO is open to all Medicare beneficiaries age 65 and over who live in communities served by the demonstration. Enrolment is voluntary, and is designed to ensure a cross-section of functionally independent and impaired elderly. Benefit package The model supplements existing Medicare benefits, which consist primarily of acute-oriented medical care delivered by primary care physicians and physician specialists, in-patient hospitalisation for acute and short-term psychiatric care , short-term outpatient mental health care, and skilled nursing home and home care services for short-term, post-acute needs. Non-institutional long-term care benefits include personal assistance services, homemaking, rehabilitation therapies, meals, respite, and adult day health care. These additional services are funded, in part, through gains in efficiency from existing Medicare benefits e. Financing Financing is accomplished through prepaid capitation. Medicare pays the Social HMO monthly, on the basis of percent of the adjusted average per capita cost for each enrolee. Inherent in this method is an economic incentive to encourage the use of home- and community-based services in lieu of institutional care. Thus, the fundamental challenge in designing the Social HMO has been in grafting a long-term care support system to a medical care delivery system. Each of the Social HMO sites were given flexibility to accomplish this goal in their own manner. Differences between sites reflect the particular orientation and experience of the sponsoring entities. Whereas Medicare Plus II and Seniors Plus emphasised the building of linkages with and between institutional- and community-based long term care providers, Elderplan and SCAN Health Plan focused on developing a managed care infrastructure, as well as medical care capabilities. Other significant differences between the sites relate to program auspices and size. All sites were required to enrol a minimum of individuals a number considered by the original designers to be important from an economy of scale perspective , although this target proved difficult to meet initially, in some cases. In both examples, however, the implementation of the model depended on managing complex provider relationships and care arrangements across a relatively diffuse organisational network. Care management, however, is a central feature at all four sites. This co-ordination function, which is the responsibility of a specialised unit at each site, allocates the long-term care benefit to enrolees who meet the above eligibility criteria. Members of the care management team include nurses, social workers and other health professionals. Their tasks include comprehensive assessment, care planning for long term care services and other expanded benefits , service authorisation and arrangement, and ongoing patient monitoring and follow-up. A multidisciplinary form of team care is used, whereby care managers and providers share patient information and discuss and recommend care decisions. There are two unique aspects of this care management system that are important to note. First, assessment and care planning activities include the elderly enrolee and family carers, as well as the primary care physician. Second, needed long term care services are delivered by providers under contract with the Social HMO. Thus, access to quality care according to agreed-upon standards is assured, as is payment to the provider. Several clinical management tools are employed in the care management function described above. The Health Status Form HSF is a screening instrument that is

conducted on enrolment and periodically thereafter, designed to identify enrolees at-risk through self-reported health status. The form collects information on current medical complaints and physical problems, and ongoing care. It is used by the Social HMO as part of a population-based, high-risk screening process to identify unmet medical and social needs that may require immediate attention, including the need for long term care. Referrals for comprehensive assessment come from two major sources: Care managers may also conduct such assessments when called for by clinical judgement. The Comprehensive Care Plan is then developed by the care manager and primary care physician, in collaboration with the enrolee and family carers. This care plan lists specific long term care goals for the patient, as well as the services needed to improve their health and functional status. The plan is also used as the basis of assigning service responsibility and authorising care. Process of care A case example will help illustrate the process of care found in this model on an ongoing basis. Our hypothetical patient, Mrs. She lives alone in a five-storey apartment building without an elevator. Her only child, a daughter, lives more than an hour away; she visits at least monthly. Box 3 follows Mrs. The medical director reviews this information, in addition to her existing medical records, and makes an immediate referral to her new primary care physician. The care management unit is also alerted to the fact that Mrs. The primary care physician sees Mrs. He finds that the patient has severe emphysema for which he orders respiratory therapy and osteoarthritis. She is taking multiple medications; several are found to be unnecessary, and will be discontinued. An appointment is made for a consultation with a neurologist participating in the network. About a week later, a care manager visits Mrs. Based on this assessment, it is determined that Mrs. A Comprehensive Care Plan is assembled by the care manager, in consultation with Mrs. The care plan includes hours of in-home services weekly, by a personal care aide. In addition, Mrs S. A nutritionist will develop a meal plan for Mrs. She will attend an adult day health centre twice a week, where special attention will be given to memory training. They communicate with each other on an ongoing basis, and work together to monitor, co-ordinate and optimise both acute and long term care. The care manager maintains regular contact with Mrs. Transportation for all health-related appointments is covered and arranged by the Social HMO. There is a substantial body of literature on the demonstration, which addresses all aspects of the model. Nonetheless, most would agree with the overall finding that the model fell short of fulfilling initial expectations, but demonstrated the value of the approach and its feasibility. The following is a general summary of major findings with regard to program outcomes: Integration Integration occurred at the financing, benefit and administrative levels, i. This, however, did not necessarily translate into integration at the clinical level. According to Harrington and colleagues [34], the Social HMOs did not achieve the integration of medical and social services, nor utilise any substantial geriatric expertise, even for frail enrolees receiving long term care. However, on the long term care side of the delivery system, frail elderly enrolees received well co-ordinated home- and community-based services through their care managers [40]. Utilisation effects The Social HMO sites did not show consistent effects on inpatient hospital and nursing home admissions and lengths of stay [33 , 41 â€” 44]. It appears that, in comparison with acute-oriented HMOs serving the Medicare elderly, the Social HMOs were associated with an increase in hospitalisation, as well as nursing home admissions for short-term, post-acute care. There are various interpretations of these findings. It may be argued that, at the time of the evaluation, these new programs were in the very early stages of the learning curve. Consequently, they were less effective in controlling access to and use of inpatient hospital and nursing home care. There are, however, alternative explanations. With respect to increased inpatient hospital use, Boose [44] and Brody [47] both suggest that this utilisation pattern reflects, in part, better medical detection and follow-up, at least in two of the Social HMOs Medicare Plus II, and Seniors Plus. Furthermore, there is contradictory evidence at the site-specific level regarding short-term nursing home use. Moreover, Brody [47] observes that the package of home- and community-based services covered by Seniors Plus, including the co-ordinated and more flexible access to personal assistance services, respite and adult day health care, had an offsetting effect on the rate of nursing home use. Costs The federal evaluation did not find overall costs savings in the Social HMO demonstration, in comparison to a large, randomly selected sample of

Medicare beneficiaries in the traditional, fee-for-service, non-managed care sector [48 , 49]. Nonetheless, expenditure patterns varied across the sites, with some sites actually providing more services for less cost in some patient groups e. Patient outcomes In this demonstration, research on patient outcomes focused entirely on enrolee satisfaction. This experience is at least as good as that found in other studies of Medicare beneficiaries enrolled in acute-oriented HMOs. Since enrolment is voluntary, evaluators also considered enrolment retention and dis-enrolment rates to be important, although indirect measures of patient satisfaction with the new model. It was reported that the Social HMOs were, as a group, more successful in retaining enrolees than acute oriented HMOs serving elderly Medicare beneficiaries. In addition, Social HMOs were found to have lower rates of dis-enrolment across all patient groups, including the most frail group, when compared to these HMOs. Implementation The Social HMOs experienced considerable difficulties during the implementation and early operational phases. This caused inefficiencies and discontinuities on the administrative, financial and clinical levels [24 , 36]. Enrolment was also slower than anticipated, resulting in higher than expected marketing costs [39]. Finally, the queuing method used to control selection bias proved to be a cumbersome administrative burden; this approach is no longer used by the remaining sites. Lessons learned While the demonstration of the Social HMO model fell short in the ways described above, three major lessons can be learned. First, the feasibility of combining responsibilities for the financing and delivery of acute and long term care services under one organisational roof was established, although not without major challenges. Second, experience with the model suggests that the reduction of inappropriate nursing home care is possible, and that a comprehensive package of home- and community-based services plus care management is key. Third, the less than optimum synergies observed between the acute and long term sides of the Social HMO, suggest that care management alone is not sufficient to produce clinical integration and cost-effectiveness across the entire continuum of care, nor to change the practice of care. This demands a true geriatric focus, based on a systematic approach to age-related medical conditions. Indeed, the process of incorporating the principles of geriatric medicine into the model, including the use of clinical protocols targeted to medical conditions and syndromes most associated with the frail elderly, has already begun to take place. The initial Social HMO sites adopted a geriatric-centred approach shortly after the evaluation was completed. The program is targeted to community-dwelling elderly with Medicare and Medicaid coverage, and who need long term care.

Chapter 3 : Florida Department of Elder Affairs - Programs and Services

Successful Models of Community Long Term Care Services for the Elderly by Ruth Bennett, , available at Book Depository with free delivery worldwide.

The paper was written while Dr. The opinions and conclusions are the authors and are not meant to reflect those of the sponsoring institutions. Abstract Objective To assess the coming challenges of caring for large numbers of frail elderly as the Baby Boom generation ages. Study Setting A review of economic and demographic data as well as simulations of projected socioeconomic and demographic patterns in the year form the basis of a review of the challenges related to caring for seniors that need to be faced by society. Study Design A series of analyses are used to consider the challenges related to caring for elders in the year Principal Findings The economic burden of aging in should be no greater than the economic burden associated with raising large numbers of baby boom children in the s. The real challenges of caring for the elderly in will involve: Conclusions To meet the long-term care needs of Baby Boomers, social and public policy changes must begin soon. Meeting the financial and social service burdens of growing numbers of elders will not be a daunting task if necessary changes are made now rather than when Baby Boomers actually need long-term care. Long-term care, financing, Baby Boomers, community-based delivery system A major public policy concern in the long-term care field is the potential burden an aging society will place on the care-giving system and public finances. This paper assesses the economic dimensions of the problem. The first half of the paper reviews the literature and logic that suggest that aging in general, and long-term care services in particular, will represent an overwhelming economic burden on society by Then, a new analysis of burden is presented to suggest that aggregate resources should not be a major issue for the midcentury economy. Finally, the paper presents four key challenges that represent the real economic burden of long-term care in the twenty-first century. These challenges are significant but different from macro cost issues. What type of economic burden might be considered overwhelming? Existing literature never explicitly defines this but the sense is that the burden might be considered overwhelming if: The discussion has significant implications for public policy and for private actors focused on developing an effective care system for the midâ€”twenty-first century. Public policy goals related to an aging society must balance the need to provide adequate services and transfers with an interest in maintaining the economic and social well-being of the nonelderly. The economic challengesdiscussed are such that public and private progress that begins in the near future will make the future burden substantially easier to handle. Definitions and Background Various aspects of economic burden are associated with an aging population: Much of the logic of the paper applies to each of these financial resource challenges. However, we focus principally on the implications of long-term care services, which along with prescription drugs, have had the fastest growing costs in the list cited. In most other countries, these items tend to be financed socially.

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Chapter 4 : The Medical Home Model of Care

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Defining and Measuring the Patient-Centered Medical Home , Journal of General Internal Medicine June Health Information Technology Health information technology, such as electronic health records EHRs , disease registries, personal health record systems and clinical decision support, is key to improving access to and sharing of patient information within a care coordination team. HIT significantly enhances the capability of the patient-centered medical home to achieve its quality and efficiency goals. By enabling providers to collect, manage, and share important patient information, health information technology facilitates communication between providers, health care teams and patients. This increased coordination, which gives network providers instant access to patient records regardless of where they seek services, improves care delivery and management. Increased use of technology also enhances communication between providers and patients and promotes patient engagement. Department of Health and Human Services Payment Reform Fee-for-service, the traditional method of paying health care providers, incentivizes quantity of health care services over quality and volume over value. As an integral part of the medical home model, payment reform restructures provider compensation to align financial incentives with health outcomes. Providers are rewarded for promoting and coordinating overall patient health and improving health outcomes while simultaneously reducing health care costs. The theory is that better coordinated care leads to healthier patients who require fewer services, saving money in the long run. Reimbursing medical practices that strive to improve care delivery through medical homes contributes to cost containment. Payment reform can also provide support for services that are not currently reimbursable â€” such as care coordination activities, adoption and use of health information technology, patient education, training to improve patient self-management of disease and enhanced provider-patient interaction. Medical home payment systems assume various forms and may rely on a combination of payment models. This extra compensation covers medical home activities such as care coordination. Additional financial compensation may also be available if specific quality targets are achieved. A few of the most common are described below. Community Health Centers Community health centers CHCs are community-based nonprofit organizations that provide comprehensive health services to people who lack access to other medical careâ€”including the uninsured, residents of rural or underserved areas and some Medicaid patientsâ€—regardless of their ability to pay. In addition to primary care, CHCs often provide dental, vision and behavioral health services, community-centered services and care integration - including health education and case management. Although CHCs essentially function as community-centered medical homes, they are increasingly applying for formal recognition as patient-centered medical homes. As of , 1, community health centers operated more than 8, health care delivery sites and served nearly 20 million patients. About 40 percent received health insurance through Medicaid, 36 percent were uninsured and about half of CHC patients lived in rural areas. For more on CHCs, click here. Management of Chronic Disease and Behavioral Health The medical home model offers an opportunity for states to reduce costs and improve care for the chronically ill. These Medicaid beneficiaries tend to have complex needs and are a major driver of health care costs. Section of the Patient Protection and Affordable Care Act also includes an option for states to provide health homes similar to medical homes for enrollees with multiple chronic conditions.

Chapter 5 : Long-term care - Wikipedia

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