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## *Models of Health Care Delivery*



**CARE SETTING AND ACUITY  
THE CONSTANTS OF LONG TERM CARE  
HEALTH PROMOTION AND DISEASE PREVENTION**

1

This module focuses on an underlying basis of the seniors' housing and care business: providing health care services to the elderly. We discuss seniors' needs for housing and health care and how the industry, other systems, and society as a whole can most effectively meet these needs.

Specific topics:

- “Typical” health characteristics of the elderly
- The current system's failure to meet these needs
- How an effective health care system would operate

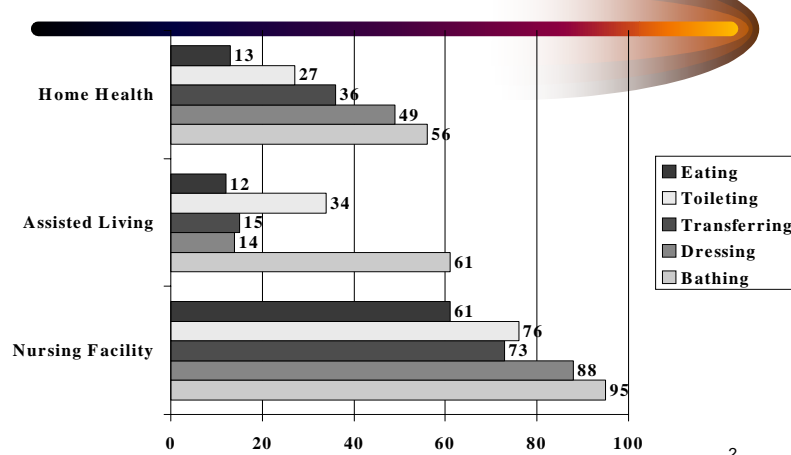
- The importance of an interdisciplinary approach to seniors' care
- Proposed standards for care

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### **NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
 “Managing Long-Term Care Services for Aging Populations”

*% of Elderly With  
 ADLs (By Setting)*



Key points:

- The pattern of impairment (that is, the ADL with which the senior needs assistance) is similar between home health care and nursing facilities; however, the *percentage* needing assistance is much higher in the latter.
- Overall, residents of assisted living facilities need less assistance than those in nursing facilities (as expected); perhaps less expected, their needs are also generally less than people receiving home health care. The

suggestion is that residents in assisted living often enjoy a greater level of independence than seniors living at home and receiving home health care.

- An exception to the previous point: required assistance in toileting and bathing is the same between assisted living and home health care.

Overall, this analysis supports the perception that seniors in nursing homes are more dependent than those receiving home health care or (particularly) in assisted living.

**NOTES:**

## And Chronic Illness



- 75% of Elderly Report One or More
- 50% of Elderly Report Two or More
- (Although 5-10% of Elderly Consume 60-70% of All Seniors-Related Health Care Resources)

3

“Chronic conditions” are long-term illnesses that will probably never be cured, although they are not necessarily fatal. These contrast with *acute* conditions, which may be very serious or life threatening but can be cured with appropriate treatment. Osteoporosis is a chronic condition, a broken hip acute.

Five of the six most common causes of death among people 65 or older are chronic. In order of incidence, they are:

- Heart disease
- Cancer

- Stroke
- Chronic obstructive pulmonary diseases
- Diabetes

(The sixth leading cause is pneumonia/influenza, each of which is acute.)

The following figures, drawn from “Older Americans 2000,” show the most common chronic diseases broken down by gender:

Disease	Males	Females
Arthritis	50%	64%
Diabetes	13%	12%
Cancer	23%	17%
Stroke	10%	8%
Hypertension	41%	48%
Heart disease	25%	19%

### NOTES:

*Meaning Potential for  
Real Impact If We...*



- Identify Those Most Likely To Benefit
- Assess (With Multidisciplinary Team)
- Develop Plan of Care (With Patient)
- Follow Up (Manage Care and Behaviors)

4

**Identify Candidates:** Particularly those at risk.

**Perform Assessment:** Assessments are currently performed by individuals rather than teams. Further, a wide range of individuals perform assessments, as reflected in the recent NIC National Survey:

1. Nurse on staff
2. Administrator
3. MD not on staff

4. “Other person”
5. Nurse not on staff
6. MD on staff
7. Head certified nurse assistant

Most if not all of these professionals—and others—should be involved in the assessment process.


**Develop Plan of Care:** Patient input into the plan is critical. In addition to their right to autonomy and choice regarding their own lives, seniors who do not agree with the plan of care are unlikely to cooperate with it. If care doesn’t start with the patient, it will certainly end there.

**Follow-up:** Effective follow-up is an ongoing reassessment that includes:

- Clear role definitions
- A team approach with good communication
- Formulation of specific, realistic individual plans of care
- Strong organizational support
- All participants’ familiarity and acceptance of the process (Pacala & Boulton, quoted in “New Ways”).

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*That’s Not the  
Traditional System*



- Single Event Focus on Urgent Problems
- Fee for Service (Fifteen Minutes at That)
- Medical Orientation and High Technology
- Emphasis on “Cure” rather than Prevention
- Emphasis on Acute (Symptoms) rather than Chronic (Functions)

5

**What is:** Single-event focus on urgent problems

**What should be:** Ongoing assessment of and response to senior’s overall condition, including emphasis on preventive care and follow-up

**What is:** Fee for service

**What should be:** Payment for ongoing service, again emphasizing preventive care and follow-up

**What is:** Medical orientation and high-technology

**What should be:** Holistic focus on the senior’s overall well-being, including such aspects as social supports and behavioral issues

**What is:** Emphasis on “cure” rather than prevention

**What should be:** Active preventive care focusing on areas in which that senior is particularly at-risk

**What is:** Emphasis on acute (symptoms) rather than chronic (functions)


**What should be:** Response to the chronic conditions previously discussed rather than waiting until they reach an acute level.

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**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*Systemic  
Weaknesses*



- Reimbursement-Driven
- Inequitable Distribution of Services
- Fragmented/Uncoordinated/Multiple Entry
- User Unfriendly
- Inadequate Support For Informal Care
- Deference to Acute Care System

6

**Reimbursement-driven:** Care is based often on what is reimbursed, not what is needed. For example: Medicaid doesn't cover assessment, which is the prerequisite for quality long-term care. Further, Medicaid is oriented mostly toward institutionally based long-term care, not at all in accord with seniors' wishes.

**Inequitable distribution of services:** More often than not, what you get is a function of where you live and how much money you have, not your condition.

**Fragmented/Uncoordinated/Multiple Entry:** Long-term care is a maze that few can negotiate.

**User-unfriendly:** The system be can difficult to negotiate. Seniors (particularly those without family members or others to help them with paperwork and other requirements) may give up and not obtain services.

**Inadequate support for informal care:** Most care is family-provided; few resources for support are available.

**Deference to acute care system:** The current systems to care for 85-year-old women are a result of decisions made 35 years ago by 55-year-old men.

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**NOTES:**

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*Access: The Confusing Array*



Home	Community	Facility
Informational/Referral	Congregate Meals	CCRCs
Case/Care Management	Legal/Protective	Assisted Living
Chore Services	Medical/Dental Care	Foster care
Home Health Aid	Assessment Clinics	ICFs/MR
Home-Delivered Meals	CMHCs	Nursing Facility
Home Nursing Care	Substance Abuse	Subacute Units
DME	Senior Centers	Rehab Hospitals
Special Transportation	Respite Care	Mental Hospitals
Respite Care	Hospice	Acute Care Hospitals
Assistive Devices	Housing Referrals	Adult Day Care
Etc.	Etc.	Etc.

7

Want proof?

One question: Shouldn't somebody who knows how to deal with these issues be available to work people through the maze? How do we tie all these services together?

NOTES:

*Obvious Need To  
Integrate Services*

- Ancillary Assistance Affects Trajectory of Chronic Illness
  - Transportation
  - Financial Management
  - Housing
  - Chore Work
  - Respite Care
  - Family Support

8

Integration of services is a critical part of providing care. Social services are particularly important, since they can provide the necessary support to seniors who otherwise could not negotiate the complex health-care system.

For example, the services described above are not “medical” in the usual sense. Support in these areas, however, can enable seniors to live more independently and postpone or eliminate the need for institutionalization. Such services as

providing transportation and cleaning the senior’s house can improve the quality of care.

Even support that may not “look like” health care may in fact contribute to the senior’s health. Activities such as disease prevention (arranging a flu shot) and nutritional services (assessing the senior’s diet, providing fresh fruits and vegetables) can improve the individual’s health and overall quality of life.

Social services can prevent a cycle in which, for example:

1. Loneliness contributes to depression.
2. The depression leads to unhealthy behavior, such as not eating.
3. That behavior causes nutritional problems.
4. The nutritional problems lead to weight loss.
5. Weight loss leads to nursing home placement.

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**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
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*Even Health Care Is  
More Than “Health”*

E.g., Prevention for the Elderly Is More Than Immunizations and Should Include:

- Respite Care (To Forestall Elder Abuse)
- Medication Compliance
- Nutritional Assessments
- Depression Screening
- Physical Activity, Etc.

9

**Respite care** relieves a family caregiver of responsibilities, either short- or long-term. Such services include home care, day care, or short-term institutional care.

**Medication compliance** depends on the senior’s memory and other factors. An assisted-living resident can be taking up to 12 medications a day; keeping track can be complicated. In addition to residents managing their own medication, this function is often performed by nurses, aides, pharmacological staff, paraprofessionals, and even cooks who distribute medications during meal times. Various state and local laws

may affect a facility’s procedures. A routine review can ensure that the senior is not taking unnecessary medication .

**Nutritional assessments** are critical to addressing chronic diseases. The assessment should address consumption of foods within such groups as grains, vegetables, fruits, and fat. Objective measures give a comprehensive, accurate assessment of the senior’s nutritional practices.

**Depression screening** is important not only to address the depression itself but because the condition can exacerbate chronic conditions. Several objective tools can provide a reliable assessment of the presence and severity of an individual’s depression.

**Physical activity** can positively affect virtually every chronic condition--or at least prevent it from progressing as quickly. Such activity can also ward off physical deterioration that can lead to frailty and, in turn, accidents or illness. For example, weight training can provide exceptional benefits to seniors, and many facilities do have weight rooms--although seniors often need to be strongly encouraged to start and continue a regimen.

*Focus Should Be On Frailty  
Prevention/Reduction*



- Most LTC Related to ADLs, Not Disease
  - True In Both Home and Facility Settings
  - Even Appropriateness of Care Based On ADLs
- Example, Preventing Falls and Fractures
  - Strength Building
  - Education
  - Medications
  - Vision Correction

10

For example, many seniors live full, healthy lives in spite of having diabetes—as long as they take their medication. Often, support in obtaining and remembering to take the medication can prevent institutionalization.

Similarly, overall physical activity is a major factor in reducing falls because it promotes general condition, balance, and other preventive factors.

Counseling can be an effective way to prevent falls and fractures. Several individuals might provide the counseling, including family members (with guidance), home health care

workers, or facility personnel. The counseling, which includes environmental assessment, might evaluate home hazards, adjust medications, reduce multiple medications, and reduce the use of sedative drugs and antidepressants.

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**NOTES:**

*We Need A  
Geriatric Model...*



- Looks at Whole Patient, Not Just Disease
- Manages Total Array of Problems
- Takes an Interdisciplinary Team Approach
- Is Knowledgeable of Community Service Options

11

Seniors' health needs are clearly different from those of younger adults and children. Accordingly, staff, medical procedures, and care must address these needs to provide a specialized approach to their care.

To this point, we have described the components of a care model that would significantly improve upon today's approach to seniors' care:

- Rather than characterizing a patient by a condition (“It’s time to see the cancer patient in Room 12”),

recognizing the individual as someone with an entire array of characteristics and needs.

- A senior may come to a hospital or other facility with a serious acute condition (such as injuries from a fall). A senior comes to long-term care with mental, social, psychological, environmental, familial and other issues—not just medical.
- Consequently, the senior might require support from professionals ranging from physical therapists to pharmacists. Rarely can an individual be treated adequately by a single discipline.
- The availability of options is meaningless if the patient or treatment team is unaware of them. Accordingly, at least one member of the treatment team must either know the community resources well or know how to identify them quickly (refer back to page 7).

The remainder of this module provides additional information on these topics.

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*Which Is Both  
Multidisciplinary...*

- Medical
- Psychosocial
- Environmental
- Behavioral
- Spiritual
- Familial



12

A multidisciplinary team performs a comprehensive assessment of the senior, typically one who is at high risk for chronic disease. Teams typically consist of a physician, nurse, and/or a social worker, all of whom have expertise in the care of older adults. Members meet individually with the patient to evaluate the issues specific to their disciplines. These issues may have surfaced during the risk-identification and initial assessment processes.

The team evaluates cultural, economic, environmental, and psychological factors to assess the senior’s overall functioning.

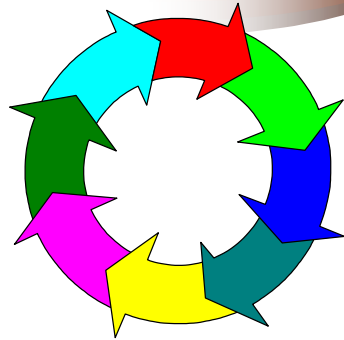
This procedure determines the senior’s medical, psychosocial, and mental capacities. Determining these capabilities and limitations enables the team to develop an overall plan for treatment and long-term follow-up (“New Ways”).

**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*And Interdisciplinary...*

- Medical
- Psychosocial
- Environmental
- Behavioral
- Spiritual
- Familial



13

The assessment should be both interdisciplinary as well as multidisciplinary. Its members should work in a coordinated, collaborative manner.

The team may include individuals from such professions as gerontological nursing and nutrition. It might even include “non-professionals,” such as transportation personnel. (This is, in fact, mandated in PACE program regulations.) These individuals often have a unique view of the senior’s capabilities and status—how long does it take them to get into the van? Do they socialize with others? Do they seem to enjoy the outings?

Transportation personnel will also hear passengers discussing issues the treatment team should know about.

The continuing dialogue among a multidisciplinary team’s providers can contribute to an ongoing assessment of every aspect of the senior’s condition, such as:

**Medical condition:** The senior’s health, nutrition, and wellness, including capability for self-care

**Psychosocial status:** Social, emotional, and coping systems available to support the individual; effect of psychosocial status on overall health

**Environment:** Cultural, economic, demographic, and psychological factors

**Spiritual:** Religious/belief systems and supports

**Familial:** Availability and willingness of family members to support the senior; family history, mores, norms as they affect the senior’s values and psychological condition

**Leisure:** Productive recreational activities that stimulate the individual resident and improve psychosocial condition

## *Requiring Systemic Changes In...*

- Provider Relationships
  - With Each Other
  - With Customer
- Practice Team Organization
- Task Delegation
- Appointments
- Follow-up Systems
- Specialty Resources

14

The system needs several specific changes to facilitate interdisciplinary assessments:

**Provider relationships:** The current hierarchy of relationships among providers from different disciplines can be counter-productive when it prevents some providers from contributing to decisions. A more egalitarian approach can identify a greater, more effective range of treatment options.

A common tendency is to identify the senior as a condition. While available time can be a problem, getting to know the senior more personally can identify hidden problems or—even

more important--the senior’s strengths and resources that can enhance treatment.

**Practice team organization:** Typically, the individual responsible for case management (ordinarily a nurse or social worker) serves as team leader, keeping other team members informed of developments, scheduling meetings, etc.

**Task delegation:** Each task must be assigned to a specific individual to establish responsibility.

**Appointments:** Someone must make sure the residents keep their appointments, including reminders and transportation.

**Follow-up systems:** Once the senior is discharged from the hospital (for example), what systems are available to meet identified needs and help provide care for chronic illnesses?

**Specialty resources:** What other resources must be provided to meet the senior’s needs? For example, if medication is an issue, the involvement of a pharmacist can help avoid such problems as interactions, dizziness, and dangerous side effects.

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## NOTES:

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*Criteria for a  
Better System*



- Is Focused on the Individual
- Is Easily Accessible
- Coordinates All Resources
- Is Integrated Within Health/Social Systems
- Is Adequately and Fairly Financed
- Includes Education and Behavioral Modification

15

The common thread among these criteria is *case management*, a process in which an individual or a team coordinates the senior’s services, often crossing institutional or disciplinary lines. The advantage is that the approach addresses all aspects of the person’s life, not just the illness or circumstances that brought the senior to the attention of the hospital or other facility.

Case management can be a very effective, cost-saving approach to care. Benefits can include systematic targeting,

clear roles and treatment protocols, proactive follow-up, and patient self-management.

One study of case management found that after 90 days from discharge, seniors who had received these services had 56% fewer hospital admissions, slightly lower costs of care, and twice as much improvement in quality of life scores. However, less structured, less proactive case management was found to *increase* hospital use and have no effect on quality of life (“New Ways”).

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**NOTES:**

*And Starts With The  
Geriatric Assessment*



“...a multidisciplinary, usually interdisciplinary, diagnostic process that quantifies a frail older person’s medical, psychosocial, and functional capabilities and limitations to design a program for therapy and follow-up care.”

16


Multiple studies have found numerous benefits from geriatric assessment:

- **Improved diagnostic accuracy:** The difficulty diagnosing seniors’ conditions requires a detailed and thorough assessment to identify “hidden” conditions.
- **Improved functional ability:** Effective assessment can identify conditions and circumstances that, if resolved, enhance the senior’s independence.

- **Increased satisfaction with care:** Assessment leads to improved care with fewer “wrong turns,” which then leads to a more positive experience for the senior.
- **Increased use of home services:** Seniors are less likely to require institutionalization.
- **Decreased mortality:** The team can identify and treat conditions before they become life threatening.
- **Decreased health care costs:** Prevention is less expensive than treatment; outpatient or home care is less expensive than institutionalization.
- **Decreased patient anxiety:** Patients have greater trust in those who are spending adequate time with them.
- **Decreased depression:** Causative factors can be resolved, and the team can treat depression earlier.
- **Decreased stress for caregivers:** Overall improvement, greater independence results in less responsibility for the caregivers.
- **Decreased use of emergency services:** Conditions are addressed before emergency care is required.
- **Decreased use of hospital services:** Early assessment allows for outpatient treatment or home care.

**The Johns Hopkins Bloomberg School of Public Health  
 “Managing Long-Term Care Services for Aging Populations”**

*Domains of Assessment*



- Physical Health
- Mental Health
- Social Support
- Environmental Adequacy

17

Components of a comprehensive assessment can include:

<b>Domain</b>	<b>Areas Often Assessed</b>
Personal	Demographics, occupation, education, religion, living situation, finances
Emotional	Depression
Functional	Ability to perform ADLs and IADLs
Nutrition	Diet
Cognition	Cognitive dysfunction
Medications	Polypharmacy, nonadherence
Psychosocial	Relationships, interactions, activities, support

<b>Domain</b>	<b>Areas Often Assessed</b>
Environment Services	Safety, convenience Community and home services used or needed
Gait	Risk of falls
Preferences	End-of-life care
Medical history	Conditions, life-style, prevention
Physical examination	Overall condition, follow-up to previously identified conditions

**NOTES:**

The Johns Hopkins Bloomberg School of Public Health  
“Managing Long-Term Care Services for Aging Populations”

*NASW Standards*



- Enhance Client Self-Determination
- Establish Primacy of Client Interests
- Assure Confidentiality
- Foster Inter-Professional Collaboration

18

The National Association of Social Workers (NASW) has established the following standards for their work. Although these standards can be applied to all client groups, they are particularly important in working with seniors.

**Enhancing client self-determination:** There is a tendency to make decisions *for* seniors rather than *with* seniors (much less encourage them to make their own). Sometimes this is necessary; a senior may not be fully aware of the options or have the

mental capacity to make such decisions. However, NASW promotes the concept that the seniors should be involved as

much as possible in deciding whether to move to a facility, what kind of facility, under what financial arrangements, etc.

**Establishing primacy of client interests:** Simply, the client comes first, and the facility should adapt to the clients’ needs, not the other way around.

**Ensure confidentiality:** Confidentiality is both a clinical principle and a legal right recognizing that client information must be on a strict need-to-know basis. Clinical and legal definitions vary, but the overriding principle is that information gained from or about the individual is be used only in that person’s interest.

**Foster inter-professional collaboration:** As discussed, seniors may have a range of needs that require the support of professionals from several disciplines.

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**NOTES:**

## *Developing the Plan of Care*



- Therapeutic or Restorative
- Supportive
- Basic Maintenance
- Preventive and Quality of Life

19

The assessment is important only to the extent it leads to an appropriate plan of care. The POC must be as oriented to the specifics of the customer as is the assessment itself.

Degenholtz et al state that...

“Formal assessments typically fail to touch on client values and preferences. That failure is evidenced by the long-standing problem of “cookie-cutter” approaches, in which two or three standard service plans are used for virtually all clients. It is indeed possible to shape care plans that are more consistent with clients’ values and to work in other ways that help clients realize their own preferences.”

The Plan of Care includes four elements:

**Therapeutic or restorative care:** Medical, mental health, nursing, and rehabilitation health and how are they different from “medical” treatment, nutrition, and skills training (for caregivers and the resident)

**Supportive services:** Homemaking, meal preparation, supporting housing, and legal and protective services

**Basic maintenance:** Shelter, food, clothing, transportation, and financial management

**Preventive activities and quality of life:** Health education, exercise and leisure, and support groups

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## NOTES:

*Follow-Up  
Is Critical*



- Self-management Should Be A Goal
- With A Focus On Assessing Outcomes
- Leading to Updates to the Plan of Care
- With a Continuing Holistic Approach

20

This module has emphasized the importance of developing an individualized health care plan that recognizes the senior’s needs and possible service requirements from a range of disciplines. Further, the use of case management and a multi-disciplinary team is an effective approach to *service*... service being the key element in the business of seniors’ housing and care. Central to this care is the assessment process, both for diagnostic purposes and to provide ongoing evaluation of the initial plan’s implementation and effectiveness.

Now that we’ve addressed effective approaches to health care, we move on to a closely related issue: how do you determine if the service is meeting the quality standards we’ve established?

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**NOTES:**