ENABLING THE COMPLEX OLDER ADULT TO LIVE AT HOME

Claudia Chaperon, PhD, APRN, GNP-BC
COMPLEX COMMUNITY DWELLING OLDER ADULTS

What Makes Them Complex?

- Complexity of System: Lack of access to needed formal institutional and non-institutional care due to fragmented care delivery systems and/or poverty?
- Medical or Psychiatric instability?
- Functional disability?
- Ethnic or racial disparities?
- Lack of informal caregiver?
- Lack of trained interdisciplinary team members to integrate and implement complex care plans?
Leading Causes of Death in U.S and Nebraska for Persons Over the Age of 65

- Heart Disease
- Cancer
- Cerebrovascular Disease (stroke)
- COPD
- Alzheimer’s Disease

(U.S. Census, 2004)
Life expectancy

At birth

Life expectancy in years

Year

At 65 years

Life expectancy in years

Year

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2007, Figure 18.
Data from the National Vital Statistics System.
Percent of People 65 Years and Over With Disability: 2006
COMPLEX CARE NAVIGATION FOR THE COMMUNITY DWELLING OLDER ADULT

ID TEAM INTEGRATION OF SERVICES ACROSS CARE SPHERES ENABLES PERSONAL AUTONOMY OF OLDER ADULTS
Ideal Patient Complex Care Experience

The patient experiences that all systems and processes are geared to them to meet their needs: a safety-oriented system that provides standardized, evidence-based care supported by technology, but that recognizes and responds to their personal needs (Gold, 2007, p. 293).
INTRAPROFESSIONAL CARE TEAM

- Informal care team members: Spouse, family, neighbors, partners, church members, and other social support.
- Formal care team members: Physician, nurse practitioner/physician assistant, physical/occupational/speech and other rehabilitative therapists, nurses, social workers, neuropsychologist, geripsychiatrist, clergy, and more.
Teamwork is Essential to Enable Older Adults to Live in the Community

Disparate attitudes about autonomy, teamwork, and administrative process among interdisciplinary team members affect safety and efficacy of health outcomes. The fragmented delivery system is part of the teams’ challenge. Limited resources, prioritization of needs, and care navigation issues make decisions difficult. More heads than one makes for better care decisions.
Access to Care for Complex Older Adults

- Access to community health services and care navigation among existing services reduces hospitalizations (Bird, et al., 2007).
- Not all older adults have Medicare insurance. Charity care for older migrant workers is on the rise (DeLia, 2006).
HOUSING

- Total Number of Residents in Certified Nursing Facilities, 2006, was 13,045.
- Nebraska has the highest number of total beds per population in nursing homes (91) and residential care/assisted living facilities (132) in the US (retirementhomes.com).
- Alaska has the lowest number.
- California ranks 14th in total number of beds per population, and the state has more residential care/assisted living beds (151,000) than nursing home beds (133,000). California has the highest number of residential care and assisted living beds in the nation (retirementhomes.com).
Life Space Constriction

- Women who seldom left their home, were 1.7 times (95% confidence interval: 1.1, 2.4; p < 0.05) more likely to become frail than women who were able to leave their homes about 4x a week.

- Homebound women experienced a threefold increase in frailty-free mortality (95% confidence interval: 1.4, 7.7; p < 0.01), after adjustment for chronic disease, physical disability, and psychosocial factors (Xue, et al., 2008)
Care Navigation Rehabilitation Reform: Outcomes for the Future

- Medicare has commissioned development of outcomes measures of medical acuity and functional status for case mix complexity of patients requiring rehabilitation across many treatment settings.
  - Continuity Assessment Record and Evaluation (CARE) tool
  - FIM instrument (originally called the functional independence measurement, but now just FIM)
  - Currently working on a cost and resource use tool
    - (Gage, et al., 2007).
Predicting the Future of Geriatric Care in Nebraska

**U.S. Census Figures**
Number of people in 2006 in Nebraska that were 65 and older:
- Women 136,259
- Men 98,396. (DHHS, 2007)

Nebraska's rank nationally in percentage of population over 65: 12th
- Nebraska's rank nationally in percentage of population over 75: 6th
- Nebraska's rank nationally in percentage of population over 85: 4th

http://www.enoa.org
Predicting the Future of Geriatric Care in Nebraska

► Did You Know?
► Of those age 60 and older in 2006 in Nebraska who accessed Aging Network Services, 76 percent lived in rural areas and 68% were female.
► 70% were age 75 and over.
► 84% of clients age 65 or older were non-Hispanic white (about 9.6% of total older population)
► 8% were non-Hispanic black (about 9.6% of total aging population)
► 6% were Hispanic (about 4% of total Hispanic population).
Will There Be Medicare/Medicaid for Baby Boomer Entitlements

- Health expenditures in 2008 outpace gross national product by 2.7 percentage points. The current revenue generated can more than compensate for this increase.
- However, at the rate of growth by 2050, the cost of health care will be 18.4% of the gross national product and it is not likely that we could afford that.
- The entitlements for care of the most complex and frail baby boomers may cause the system to go broke. The solutions will involve a piece of all of the following:
  - Increase taxes
  - Decrease reimbursement for Medicaid and Medicare
  - Reform the health care system (Aaron, 2007).
The Institute of Medicine’s Ten Rules to Transform Health Care Delivery

► Care based on continuous healing relationships
► Customization based on patient needs and values
► The patient as the source of control
► Shared knowledge and the free flow of information
► Evidence-based decision making
► Safety as a system priority
► The need for transparency
► Anticipation of needs
► Continuous decrease of waste
► Cooperation among clinicians (IOM, 2001)
Realizing the Quality Ideal of the “Medical Home”

The principles of patient-centered “medical homes” is that every person will have their own personal physician, in a strong clinical practice, that is equipped to meet the comprehensive, whole person, coordinated care needs, while assuring continued quality and safety, access, and reimbursement for each person’s needed services (Backer, 2007).
Interdisciplinary Education Is Needed to Build Health Care Providers for the Future

References

References


