

RCCHI Healthy Seniors Workgroup Recommendations

Executive Summary

The Finger Lakes Health Systems Agency (FLHSA) convened the Regional Commission on Community Health Improvement (RCCHI) to identify community goals, measures, and strategies that integrate and coordinate activities to meet the complex needs of individuals across the spectrum of their care. Existing research and local data informed the Commission's establishment of Healthy Seniors, one of three workgroups, to build upon the Sage Commission's recommendations to transform senior health care in the Finger Lakes region.

Adults age 65 and over are the fastest growing demographic nationally and in the Finger Lakes region. The regional health care system is not positioned to address the complex health and social needs of this growing population segment. Its health and social needs should be addressed together, as they are intertwined. Building upon the recommendation of the 2011 Sage Commission, the workgroup envisioned a person-centered, coordinated, and integrated healthcare model to optimally meet the needs of seniors. In this model, care is integrated across medical care, social supports, and behavioral health. Each of these domains is essential to the health and well-being of the individual, with inadequacies in any one domain, adversely affecting other domains, and ultimately, the health of the individual.

The proposed model of integrated healthcare differs markedly from its current, fragmented state. The workgroup identified a need to make the entire system holistic, with the senior at the core of the coordination and integration. The individual is supported by a patient-centered medical home care team of medical providers who work with behavioral health providers to address mental and/or substance abuse needs, with support from an array of community supports and services. To address this transformation, the workgroup proposed a series of recommendations that focus on strengthening care within each domain – medical care, behavioral health, and long-term services and supports– as well as integration across these domains. The workgroup recommendations center on four areas to transform senior health care in the Finger Lakes region – integration, workforce development, information sharing, and financing.

Introduction

Regional Commission on Community Health Improvement

Over the past several years, regional, state, and federal health care initiatives (e.g., the FLHSA 2020 Performance and Sage Commissions, CMS Care Transition Intervention initiatives, Health Homes (HH), Regional Behavioral Health Organizations (BHO), and Accountable Care Organizations (ACO)) have increasingly highlighted the need for a patient-centered, coordinated, and integrated system of care to best address patients' needs, optimize resources, and improve care. In alignment with these initiatives, the Finger Lakes Health Systems Agency (FLHSA) convened the Regional Commission on Community Health Improvement (RCCHI), a multi-stakeholder group, to develop community goals, recommendations, and measures to address the complex medical, behavioral, developmental, and social needs of individuals.

RCCHI included representatives from a variety of fields, including: hospitals and health systems, long-term care and aging services, consumer representatives, school districts, primary care providers, social service providers, institutes of higher education, public health, and the business community. The Commission met 12 times between November 2013 and March 2015 to improve health outcomes by facilitating the integration and coordination of health care in the nine-county Finger Lakes region.

The Commission identified unlimited purview as too broad and ambitious to allow for meaningful recommendations. In order to narrow and ultimately define areas of focus, commission members requested more information for several health care sectors. Existing research and local data informed commission members' selection of three areas of focus— Behavioral Health, Senior Health, and Prevention and Public Health - for development of community-wide goals and corresponding recommendations to achieve them.

Senior Health

Adults age 65 and over are the fastest growing demographic nationally and in the Finger Lakes region. Projections indicate that the national older adult population is expected to increase by 38 percent from 2007 to 2025. By 2025, adults age 65 and over are projected to comprise 21 percent of the region's

population (Sage Commission, 2014). Moreover, the number of seniors living with chronic conditions is expected to double between 2000 and 2030 (Sage Commission, 2014). Chronic conditions, often associated with co-morbid behavioral health disorders, require the provision and coordination of a wide array of geriatric care and services.

Traditionally, family members and other “informal caregivers” provided and coordinated much of this care. Today, nearly 2.2 million individuals in New York State provide care to persons age 65 and older who need assistance with day-to-day activities (New York State Family Caregiver Council, 2009). Informal caregivers provide at least 80% of community-based long-term care (New York State Family Caregiver Council, 2009). Societal trends and demographics strongly influence the availability of informal caregivers. Fewer children, increased participation in the labor force by women, and geographic dispersion of family members are among the many reasons cited for a projected reduction in informal care. The diminishing ability of family members to provide and coordinate this care, essential to the health and well-being of seniors, is of concern. In the Finger Lakes region, the caregiver ratio among seniors is projected to decline from 6.4 caregivers to 1 older adult in 2010, to 4.1 caregivers to 1 older adult in 2030 – a decline of 36% (FLHSA Hospice Plan, 2015).

Recognizing the increased demands the senior population will exert on the regional health care system, the FLHSA-sponsored Sage Commission designed a comprehensive long-range plan in 2011 to expand and enhance housing options and long-term services and supports to enable seniors to receive care, in its broadest sense, in the least restrictive setting. Recommendations set forth by the Sage Commission centered on creating a person-centered health system, accommodating to older adults’ residential preferences, and delaying institutional care as long possible. Anticipating an attendant reduction in long-term institutional care, the plan also called for a rebalancing of the long-term care system. The Sage Commission projected that by 2025, regional demand for Medicare home health services would increase by 65,000 units, state and county-funded home health visits by 1,041,000; and personal care aide and other home health funded services by 785,000 units.

Despite wide-spread community endorsement of the plan, transformation to person-centered care has been slow to transpire. The consensus of the workgroup is that the regional health system is not currently able to meet the needs of its growing senior population. The supply of home and community health services (e.g., transportation, respite care, spiritual needs, home health services, and adult daycare) is insufficient given projected demand. In addition to insufficient supply, access to long-term services and supports is further restricted for individuals with limited financial resources. Seniors ineligible for

Medicaid and without adequate personal resources to pay for needed services represent a unique challenge to the healthcare system. Paradoxically, provision of these services is essential to seniors' independence; without them, more expensive, albeit government-funded institutional care becomes the default option. Provision and payment of these resources, essential to seniors' health and well-being, have not received adequate attention or sustainable funding.

The regional health care system is not positioned to address the complex health and social needs of this growing population segment. Given this environment, the impending boom in the senior population, and the strain this population will exert on the health care system, RCCHI moved to form the Healthy Seniors workgroup to build upon the Sage plan and develop recommendations to transform senior health care in the Finger Lakes region.

Healthy Seniors Workgroup

The RCCHI charged the Healthy Seniors workgroup to collaborate across the region to advance the following vision:

Older adults throughout the Finger Lakes Region will enjoy healthy meaningful lives, functioning optimally, and participating actively in the lives of their communities.

The 40-member workgroup included representatives from a wide cross-section of professions, agencies, and institutions, including: hospitals and health systems, long-term care and aging services, consumer representatives, primary care and social service providers, public health, and institutes of higher education. The workgroup met 12 times between March 2014 and March 2015 to establish priorities for the region. Its work was grounded in the Triple Aim of improving population health (including reducing disparities), delivering quality care to individuals, and reducing per capita costs (Berwick, Nolan, & Whittington, 2008).

TRANSFORMATION TO PERSON-CENTERED, COORDINATED, INTEGRATED CARE

Building upon the recommendation of the Sage Commission, the workgroup envisioned that a healthy senior population is best achieved through a person-centered, coordinated, and integrated healthcare model. In this model, care is integrated across medical care, social supports, and behavioral health. Each of these domains is essential to the health and well-being of the individual, with inadequacies in any one domain, adversely affecting other domains, and ultimately, the health of the individual. For purposes of this report and the recommendations it contains, the workgroup defined the following terms with respect to seniors:

“Person-directed care” is care and services determined and directed by the individual and/or caregiver.

“Person-centered care” is a comprehensive focus on the “whole person”, including social, behavior, and spiritual health (Maslow, 2013) (Starfield, 2011). Patients are equal partners in their care planning and involved in shared-decision making as their care plan is developed and managed.

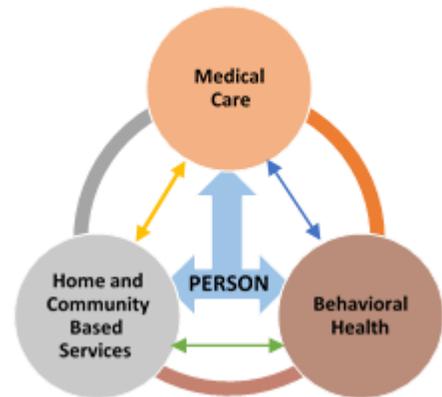
“Patient-centered medical home describes a collaborative relationship between patient and care providers and includes: managed chronic care, coordinated medical, behavioral and social needs, evidenced-based treatment, and systematic monitoring of outcomes at both individual and population levels. While the primary care practice is usually the site of the PMCH, its location differs according to the specific needs of the patient.

“Population health”¹ refers to the health outcomes achieved in a defined group of individuals as a result of healthcare, public health interventions, and the social and environmental determinants of health.

Limited evidence suggests that patients requiring complex medical and behavioral management demonstrate better outcomes when they participate as part of an integrated and coordinated care plan (Park, Miller, Tien, Shephard, & Bernard, 2014)(Beland & Hollander, 2011). The advancement of

¹ Institute for Population Health Improvement, UC Davis Health System

Patient-Centered Medical Homes (PCMH) in the Finger Lakes region represent a step toward integrated care, but do not constitute fully-integrated care as envisioned by the workgroup. Its vision includes widely-implemented PCMHs with integrated behavioral health and non-medical community-based services. This transition requires a cultural shift from transactional healthcare to holistic healthcare.



The proposed model of integrated healthcare differs markedly from its current, fragmented state. Limited awareness and understanding of available resources, constrained access to these resources in both urban and, particularly, rural settings, lack of effective communication and coordination, and financial and regulatory constraints contribute to fragmented care delivery. Healthcare silos present multiple challenges for each care domain; the primary care provider has limited resources for referrals, while behavioral health and community resources are often not integrated with medical services. As people age, they and their families often rely on a wide range of additional supportive services, such as adult day care, home health care, non-medical home care, hospice, home-delivered meal programs, transportation, and other long-term services and supports. While an array of these services are offered in the region, holistic assessments of an individuals' needs are infrequent and the coordination of multiple services, across multiple organizations to address those needs, is rare.

The workgroup identified a need to make the entire system holistic, with the senior at the core of the coordination and integration. The individual is supported by a PCMH care team of medical providers who work with behavioral health providers to address mental and/or substance abuse needs, with support from an array of community supports and services. This clinical-community partnership fosters the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care, and non-clinical partners such as community centers, faith-based organizations, and home-delivered meals. Together, the clinical and community services can better meet the varied needs of every older adult.

Person-centered care is long-term, supportive, and sustained by integrated, medical, behavioral, and social services. To address this transformation, the workgroup proposed a series of recommendations that focus on strengthening care within each domain – primary care, behavioral health, and long-term services and supports, as well as integration across these domains. Strengthening care within these domains and integrating care across them enhances delivery of person-centered care, in which seniors inform and

actively participate in the development of their care plan and become an integral part of a shared, decision-making process. The workgroup recommendations center on four related areas – integration, workforce development, information sharing and financing. The recommendations address key barriers to transformation to person-centered, coordinated, integrated care for seniors. The workgroup recognizes that differing circumstances (e.g., disease burdens, location (urban/rural), resources, demographic profile) across the region require tailored solutions. As such, the recommendations are intentionally general to guide, not prescribe, regional initiatives to achieve person-centered, coordinated, integrated care for seniors in the Finger Lakes region.

Recommendations

In the person-centered care model, the health infrastructure ensures complete access to care, encourages coordination of care across the three domains, and considers the “whole person” in the plan. Implementation of this model, including the integration of social and behavioral services, has begun in the region. Transformation is slow with varying levels of integration achieved. To support complete transition to a widely-implemented, integrated, and coordinated health delivery stem, the workgroup recommended:

Integration Recommendation #1: Create multidisciplinary care teams of clinical, behavioral, community- and faith-based care providers. Foster relationships among these providers to work together to manage the complex medical and social needs of seniors.

Integration Recommendation #2: Expand PCMH to include co-location of services.

- Expand telehealth

- Partner with community-based organizations

Integration Recommendation #3: Develop regional standards and protocols for real-time data entry and information sharing across medical care, behavioral health, and home and community-based services.

Integration Recommendation #4: Implement an integrated IT solution to support population health management.

Integration Recommendation #5: Expand RHIO connectivity and services across medical care, behavioral health, long-term care and community settings.

The workgroup recognized that implementation of the PCMH is a starting point in the delivery of integrated and care. Communities’ needs and resources differ across the region. As such, integration

may occur with different organizations partnering across the region. In rural areas, cross-agency and cross-county collaborations are likely to develop in an effort to successfully implement PCMH.

Workforce

The healthcare transformation envisioned requires a workforce of professional teams replete with the knowledge, skills, and behavioral capacities to optimally manage the health of the senior population. As new care requirements and workflows emerge, altered roles and responsibilities highlight the need for a coordinated approach to workforce development, staffing, and reimbursement. These workforce issues are common to all RCCHI workgroups. As such, the RCCHI Blueprint should include a recommendation that the FLHSA develop a workforce consortium to coordinate and design a regional healthcare workforce plan. The recommendations below, recommended by the Healthy Seniors workgroup, could be addressed by the planned workforce consortium.

Workforce Recommendation #1: Strengthen the healthcare workforce to better serve older adults with complex medical, behavioral, and social needs. Specifically:

- a. Build a skilled provider base of “hands-on” caregivers to address the health needs of the geriatric population. Additional social workers, advanced practice psychiatric nurses, NPs, PAs, and licensed mental and behavioral health counselors are required to meet the growing healthcare requirements of seniors.
 - Define the new roles / types of providers and responsibilities necessary to facilitate team-based, geriatric skilled, primary care that integrates behavioral health (both mental health and substance abuse) and social supports.
 - Promote a diverse multilingual/multicultural workforce that reflects the communities it serves.
- b. Coordinate with educational institutions to develop new curricula and include the attitudes, beliefs, and skills in management of older adults, particularly those with complex comorbid illnesses.

- c. Identify policy solutions to address workforce shortages, scope-of-practice issues, and other barriers that create challenges to delivering effective long-term care services to seniors living in communities.
- d. Create inter-professional partnerships that work effectively as multidisciplinary teams – within practices, and across care settings with community partners.
- e. Determine the finances required to support training to develop a sustainable approach to the identification, development, recruitment and retention of the needed workforce.
- f. Leverage with local, NYS and federal workforce strategies (e.g., NY-SHIP, DSRIP, OPWDD, FLHSA Sage).

Information Sharing

The workgroup acknowledged that information sharing is fundamental to integrated, effective healthcare. Currently, inter-system variations exist as to who, what, where, when, and how medical records and information are documented, maintained, and shared. E-record connectivity is limited across systems, with electronic access to community-based services particularly lacking. These variations hinder coordinated and effective use of health data and relevant social services. Additional investment in IT resources is needed to support data's expanded role in health care. To address these barriers the workgroup recommended:

Information sharing #1: Improve data management, sharing, and transfer, including:

- a. Develop a regional IT strategy to support data sharing.
 - Ensure interoperability across systems
 - Implement widespread adoption of secure, interoperable HIE
 - Develop regional standards and protocols for real-time information sharing and data entry
 - Track and report services with real-time information sharing with and from community care providers
 - Strengthen bidirectional sharing of decision support systems

- b. Expand RHIO adoption and participation in RHIO direct.
- c. Leverage investment and build upon existing HIE platform and data sets (e.g., OA, PeerPlace RHIO).

Information sharing #2: Commit to integrating information and addressing regulatory barriers to sharing protected behavioral health and substance abuse information, while ensuring client confidentiality and security of all health-related information.

Information sharing #3: Create data warehouse, including medical, social, and behavioral data that facilitates regional healthcare analysis at the population level.

- a. Develop strategies to use OA annual data and create an infrastructure for analysis.

Financing

Several different government programs, including Medicare, Medicaid, the Older Americans Act (OAA) and Social Services block grants, finance most long-term services and supports. Over the last several years, funding for these services has remained essentially flat per episode of care. Seniors just above the Medicaid threshold are particularly vulnerable - ineligible to receive government-funded coverage of essential services and without adequate financial resources to meet their needs. One-half of low-income seniors express concern about having adequate resources to last them for the rest of their lives (NCOA, 2014). Expanded In-home Services Elderly Program (EISEP) is a program that provides reimbursable home-based services to the elderly, however the waiting lists for the program are long; many can't access the benefit. As such, additional funding for these services is needed to increase seniors' ability to remain at home. To address these barriers to senior independence the workgroup recommended:

Financing Recommendation #1: Advocate for the expansion of Medicaid/Medicare coverage of non-medical long-term services and supports.

Financing Recommendation #2: Contract with managed care and other payers using a value-driven payment system that includes cost sharing and sliding scale contributions.

Financing Recommendation #3: Facilitate contracting between health systems, skilled nursing facilities and long-term services and supports agencies to deliver care in gain-sharing and value-based care delivery models.

Research and Measurement

Lastly, although the workgroup did not identify research as a specific area of transformational change, it recognized the role of research and measurement in the development and evolution of an integrated system. Accordingly, the working group recommended the following research and measurement initiatives:

Research and Measurement Recommendation #1: Conduct research to develop a better understanding of the specific needs of seniors whose incomes are above the Medicaid threshold.

Research and Measurement Recommendation #2: Carry SAGE metrics forward to measure progress and reprioritize areas of focus.

Research and Measurement Recommendation #3: Perform ongoing assessment to identify populations with healthcare disparities.

Research and Measurement Recommendation #4: Identify metrics to evaluate the advanced integration care model (PC+BH+long-term services and supports).

- Measure senior population health outcomes

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