The Role of Area Agencies on Aging and Disabilities in Geriatric Healthcare

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Disclosure

No disclosures

The views and opinions in this presentation are that of the presenters and do not necessarily represent the official views of HRSA or the U.S. Department of Health and Human Services

Learning Objectives

- Discuss the role of Area Agencies on Aging and Disabilities in helping community-dwelling older adults and caregivers manage their social and clinical needs
- Name evidence-based programs and approaches that support self-efficacy, positive health outcomes and quality of care for older adults
- Explain how family caregivers can be engaged and supported as part of a healthcare team

Agenda

1. Introductions and Background
2. Area Agency on Aging (AAA) Overview
3. Role of AAAs in Geriatric Healthcare
4. Case Studies
5. Next Steps
6. Questions

Northwest Geriatrics Workforce Enhancement Center (GWEC)

We're a federally funded regional center that conducts inter-professional education and training programs to improve the primary care of older adults in the Northwest United States.

Our Goals:

- Develop clinical training environments integrating geriatrics and primary care.
- Develop providers who can address the needs of older adults.
- Deliver community-based programs that provide patients, families and caregivers with knowledge and skills to improve health outcomes and quality of care for older adults.
- Provide Alzheimer's disease and related dementias (ADRD) education to families, caregivers, direct care workers and health professions students, faculty, and providers.

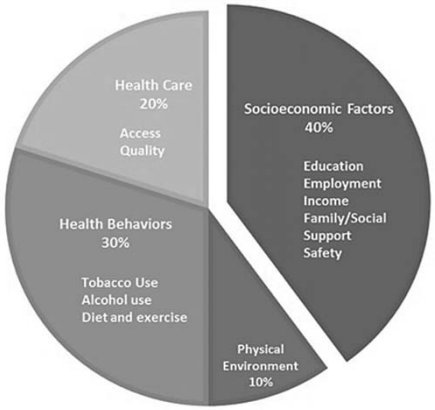
NORTHWEST GERIATRICS WORKFORCE ENHANCEMENT CENTER

Primary Care Liaisons

Goal: Enhance primary care awareness of community resources that support older adults to age in place.

Where Health Happens

- Interactions across the social determinants affect a wide range of health, functioning and quality of life outcomes
- Community role in optimizing primary care and health outcomes among older adults



Source: Office of Disease Prevention and Health Promotion. Healthy People 2020

Area Agency on Aging Overview

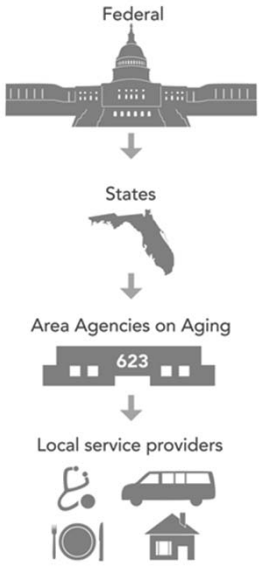
AAAs Across the Nation

- Nationally established in the 1973 Older Americans Act (OAA)
- Designated “on the ground" organizations charged with helping vulnerable older adults live with independence and dignity within their communities.
- All AAAs play a key role in:

Regional Delivery

National Aging Network

- Administration on Aging - Federal Oversight
- State Units on Aging
- Local AAAs
- Contracted Service Providers



Partnerships

In addition to direct service providers, AAAs build informal and formal partnerships with other entities

AAAs, on average, have 11 informal and 5 formal partnerships with other entities. These are some of the most common. By percentage of AAAs:

Adult Protective Services	85%	Disability service organizations	75%
Transportation agencies	84%	Public Housing Authority	75%
Medicaid agencies	83%	Faith-based organizations	66%
Advocacy organizations	82%	Community health care providers	60%
Emergency Preparedness agencies	79%	Businesses	46%
Hospitals	79%	Managed Care/HMO networks	42%
Mental Health organizations	77%		

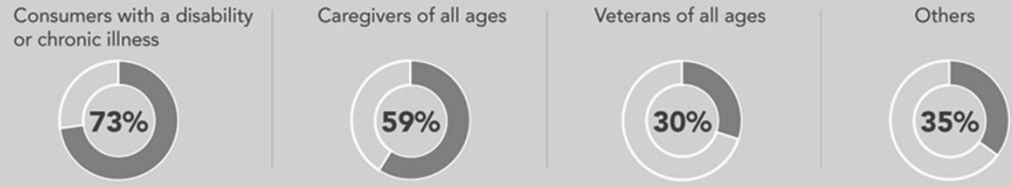
Populations Served

- OAA targets older adults (60+) and their caregivers
- Particular focus on those in greatest economic & social need including:
    - Low income
    - Rural and socially isolated
    - Ethnic and cultural minorities
    - Limited english proficiency
    - Individuals at risk of institutionalization
- OAA services currently reach one in five older adults

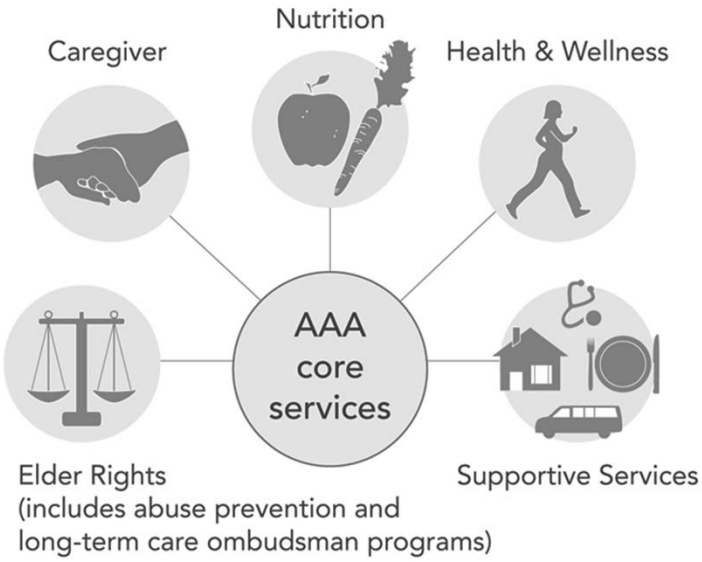
AAAs Serve a Broad Range of Consumers

While all AAAs serve adults age 60 and older and their caregivers, they also serve younger consumers, such as …

Percentage of AAAs that serve consumers under age 60, by category:



All AAAs offer five core services under the OAA:



Roles of all AAAs

assess community needs and develop and fund programs that respond to those needs;	**educate and provide direct assistance** to consumers about available community resources for long-term services and supports;
serve as portals to care by assessing multiple service needs, determining eligibility, authorizing or purchasing services and monitoring the appropriateness and cost-effectiveness of services; and	as **custodians of the public interest,** demonstrate responsible fiscal stewardship by maximizing use of public and private funding to serve as many consumers as possible.

AAAs must:

Know **WHAT** impacts health

Identify **WHERE** there are vulnerable populations at greatest risk

FOCUS on areas of greatest need, and

COLLABORATE with others to meet those needs

AAA Roles in Geriatric Healthcare

Focal Point & Assessment

- Objective information about community-based services amid an array of options
- Identification of appropriate programs, screening and enrollment
- In-person assistance navigating and applying for public benefits
- Coordination with appropriate entities to determine financial and functional eligibility for LTC options
- Facilitate informed decision making and “right-size” approach to care

Health Promotion and Self-Management

- Develop, adopt and/or expand evidence-based health promotion and disease prevention programs
- Often offered in collaboration with senior centers, meal sites, and healthcare providers
- Nearly all AAAs deliver at least one program with demonstrated results in the following areas
  - Self-Management Education and Disease Prevention
    - Stanford “Living Well” Chronic Disease Self-Management Program (CDSMP)
    - Diabetes Self-Management Training (DSMT)
    - Powerful Tools for Caregivers
  - Physical Activity and Falls Prevention
    - EnhanceFitness
    - Matter of Balance
    - Tai-Chi Moving for Better Balance

Health Promotion and Self-Management

Improved health status across several variables

Improved health behaviors

Fewer ER visits and hospitalizations

Intervention Name	Intervention Type	Target Audience	Setting and Delivery	Health and System Benefits
EnhanceFitness	Physical activity	Older adults wishing to maintain or improve their physical functioning	• Community settings and senior apartments • Groups of up to 25 • Three weekly 1-hr sessions	↑ Overall functional fitness and wellbeing ↓ Total health care costs for participants
Matter of Balance	Falls prevention	Ambulatory older adults concerned about falling and who have restricted their activities	• Community settings • Small groups of 8-12 • Eight 2-hr sessions	↓ Fall risk and fear of falls ↑ Self-efficacy ↑ Physical activity ↓ ER visits
Living Well CDSMP	Self-management education	Adults with chronic conditions	• Community settings • Workshops of 8-12 • Six weekly 2½ hour sessions	↓ ER/outpatient visits ↓ Health distress ↑ Cognitive symptom management ↑ Self-efficacy
Powerful Tools for Caregivers	Self-management education / Caregiving	Family caregivers of adults with chronic conditions	• Community settings • Small groups of 10-15 • Six 90-minute weekly sessions	↑ Self-efficacy ↑ Use of exercise, relaxation, and medical checkups

Care Coordination and Management

- More in-depth and ongoing than information-giving and assistance - individuals managing multiple clinical and social needs
- Promote person-centered health action planning to empower patients to take charge of their own health care
- Increased coordination between the client and all of their healthcare providers
  - Encourages involvement and independence
  - "The Right Care, At the Right Time, with the Right Provider"
- Study conducted in WA State - savings of $248 per member, per month
- Multiple service types: state level initiatives vs. AAA-individual initiatives

Jingping Xing, Candace Goehring and David Mancuso. Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs Health Affairs, 34, no.4 (2015):653-661

Patient and Caregiver Engagement

- Translation of patient health goals from the clinical to the community context
- Removing barriers to implementation of care plans through access to resources
- Working upstream to plan for an individual's ability to age in place:
  - Transportation
  - Food Insecurity
  - Safety
  - Housing/Utilities
- Family Caregivers as a part of the healthcare team

Collaboration with Family Caregivers

No "one size fits all" approach

Caregiver identity

Encouraging self-care

Long-term planning

"*Linking caregivers to resources throughout the disease trajectory is important because caregivers are often unaware that there are support services available to help them…"*

Reinhard SC, Given B, Petlick NH, et al. Supporting Family Caregivers in Providing Care. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 14. Available from: https://www.ncbi.nlm.nih.gov/books/NBK2665/

Family Caregiver Support Program

- Focuses on the unpaid caregiver and the system that supports the caregiver
- Includes:
  - Information and Assistance
  - Assessment and personalized care planning
  - Support groups
  - Advice on using supplies and equipment
  - Caregiver training and self-management education
    - e.g. Powerful Tools for Caregivers
  - Respite care services

Transitions of Care

Designed to support transition from one care setting to another:

- Post-hospitalization support - can include medication reconciliation

Divert patients from premature institutionalization:

- Ensure that patient has access to care in the safest setting of their choice

Incorporates elements of MI and supportive decision making

Evidence-Based Models to Support Care Transitions:

- Care Transitions Intervention (CTI)
- Bridge Model of Transitional Care

Case Study 1

- 59 y/o male - Dx of HTN; HIV-2; Anxiety; Depression; Dementia; Acute Kidney Failure; Neuropathy; Glaucoma
- Referral from his PCP states “Pt is in the process of applying for SSI and has a disability determination services appointment tomorrow: Pt is concerned about case worker’s reliability”
- Second referral for this patient in the last month. Previous referral patient declined any form assistance - I&A Specialist mailed information on Medicaid LTC

Outcomes:

- Upon follow up from I&A specialist, patient disclosure of increased depression symptoms and inability to manage his care, follow up on previous information or applications
- Assistance with completing LTC application
- Patient now receiving ongoing LTSS incl. personal care assistance, medication management, diabetic foot care
- Increased pt engagement in managing symptoms

Case Study 2

- Caregiver (CG), Cheryl, caring for husband (CR) who had a stroke 4 years ago. Only utilizing intermittent services - purchasing supplies and support groups
- CR dx with Vascular Dementia - decreased ability to care for himself and now needing increased assistance with eating, repositioning, O2 use and limited communication
- CG valued providing care in the home but no longer felt confident in her ability to manage husbands personal care needs and needs of teenage son

Outcomes:

- CM worked with CG to create a new care plan at home - connected to respite, counseling, caregiver training, and ongoing support groups
- Increased CG self-efficacy throughout the course of husband’s disease
- Increased CG self-management of psychosocial and physical health needs
- Care receiver’s personal care needs continue to be met in the home, delaying need for institutional LTC

Case Study 3

- 68 y/o female dx of osteoarthritis; diabetes; depression
- Limiting physical and social activity due to chronic pain
- Enrolled in CDSMP workshop - held at local hospital and offered to group of patients in partnership with local AAA

Outcomes:

- Increased engagement in conversations with physician
- Increased engagement in decision-making regarding treatment
- Increased self-efficacy in understanding and using medication
- “Since participating in the Chronic Pain workshop, I am now more active. I also like using the action plans. Goal setting works. Sometimes I would set lofty goals that were unreachable, but now I know to set goals that are attainable. I also choose to add on goals each week.”

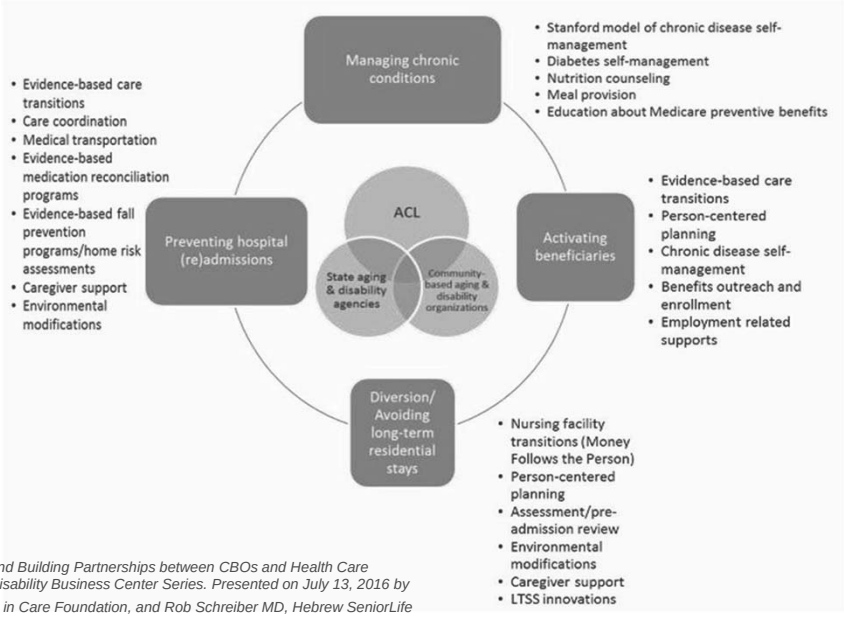
Case Study 4

- “Sam” - 80 year old, “Frequent Flyer” referred to AAA from a local hospital - Diagnosed with heart disease, DM II, HTN, Kidney Failure. Patient and family were Spanish speaking, only
- Wife was having difficulty managing his medications due to difficulty reading medication labels
- TC Coordinator met with patient, his wife and their two adult daughters

Outcomes:

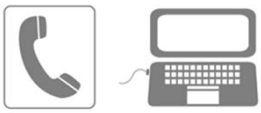
- Reviewed plan of care with TC Coordinator who developed assigned roles for each family member, lessening each of their burdens
- Medications reviewed and translated for ongoing management
- Application to LTC services - daughter is now the paid caregiver, decreasing client’s feeling of burden on his family
- No readmissions for over 3 months

Putting It All Together



Source: "Finding Champions and Building Partnerships between CBOs and Health Care Entities." National Aging and Disability Business Center Series. Presented on July 13, 2016 by June Simmons MSW, Partners in Care Foundation, and Rob Schreiber MD, Hebrew SeniorLife

Connecting Patients To AAAs



The national Eldercare Locator toll-free hotline helps consumers connect to these local resources!

800.677.1116
www.eldercare.gov

Other considerations:

- Adult Protective Services
- Long Term Care Ombudsman
- State Health Insurance Assistance Program (SHIP)

Making a Referral to AAAs

- Each AAA may have established process for receiving and responding to referrals from healthcare providers. May include:
  - Phone, secure email, and/or fax
  - Follow up with provider regarding contact outcomes
- Establish patient consent
- Visit Eldercare Locator to identify local website and information number
- Can also work through a liaison or point of contact at AAA

Why the AAA is Contacting You

Mutual Clients

- Obtain clinical history to determine appropriate services
- Documentation for service and/or equipment authorization and payment
- Coordination of care during transition or change in client condition

Closing the gap:

- Improves patient experience and satisfaction
- Results in better clinical outcomes
- Reduces risk of avoidable hospitalizations and healthcare use

What's on the Horizon?

- Shift to value – new partnerships and bridging roles
- Integrated Care – combined delivery, management and organization of services across multiple systems
    - Medicaid Managed Care
    - State Duals Demonstrations
    - Section 1115 Medicaid Demonstration Waiver

Resources

National Association of Area Agencies on Aging (n4a) - www.n4a.org/

Northwest Geriatrics Workforce Enhancement Center (NW GWEC) - www.nwgwec.org

Eldercare Locator - www.eldercare.gov

Evidence-Based Models, Data, Publications:

Care Transitions Intervention - http://caretransitions.org/
Bridge Model of Transitional Care - http://www.transitionalcare.org/the-bridge-model/
Stanford "Living Well with Chronic Conditions"- http://patienteducation.stanford.edu/programs/
EnhanceFitness- http://www.projectenhance.org/enhancefitness.aspx
Powerful Tools for Caregivers - https://www.powerfultoolsforcaregivers.org/
Tailored Care (TCARE) - http://tailoredcare.com/

Thank you!

Questions? Contact us:

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