Community Based Medical Models for Aging in Place
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Objectives

• Discuss the importance of improving the quality of health care offered to the elderly in the community
• List the basic criteria identified by the World Health Organization needed for healthy aging
• Review the role of stakeholders in designing, improving, and implementing new models of care in the community
• Identify a community care program that might be implemented in the community you serve
“We can learn from other countries as much as they can learn from us...If you see something different, your imagination can take you to new places.”

Dr. Heidi White  
Former President  
The Society for Post-Acute and Long Term Care Medicine/American Medical Director Association
Statistics

The World Health Organization reports:

– Between 2000-2050, the number of people age 60 and over is expected to double.
– In 2050, more than 1 in 5 people will be 60 and older
– By 2050, 80% of older people will be living in low and middle income countries.
What is needed for healthy aging?
To foster healthy aging, we need:

• to change the way we think about aging and older people.
• to create age friendly environments.
• to develop systems for longer term care.
• align the health system to the needs of older people.
Community Engagement: Three Big Ideas
Before starting:

– Be clear about your purpose or goals and the populations and/or communities you want to engage.
– Become knowledgeable about the community’s culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history and experience with efforts by outside groups to engage it in various programs.
For engagement to occur:

– Go to the community, establish relationships, build trust, work with formal and informal leadership, and seek commitment from community organizations and leaders.

– Remember and accept that collective self determination is the responsibility and right of all people in a community.
For engagement to succeed:

– Partnering with the community is necessary to create change and improve health.
– All aspects of community engagement must recognize and respect diversity of the community.
– Community engagement can only be sustained by identifying and mobilizing community assets and strengths and by developing the community’s capacity and resources.
For engagement to succeed:

– Be prepared to release control and be flexible enough to meet changing needs.
– Community collaboration requires long-term commitment by engaging organization and its partners.
Models of Care

**Aging in Place**
- Just for Us
- Home Based Primary Care (Veteran’s Affairs)
- Care for Older Adults and Caregivers at Home (COACH)
- Beacon Hill Village
- Senior PharmAssist

**Long Term Care**
- The GreenHouse® Project
- Program of All – inclusive Care of the Elderly (PACE)
- Charles House Association
Examples in Action

AGING IN PLACE
Home Based Primary Care
Veterans Administration, USA

• Health care services are provided in the Veteran’s home to those who have complex health care needs and for whom routine clinic-based care is not effective.
  – Eligible veterans for the program include those who need skilled services, case management and assistance with ADLs.
Geriatrics and Extended Care

Home Based Primary Care

What is it?

Home Based Primary Care is health care services provided to Veterans in their home. A VA physician supervises the health care team who provides the services. Home Based Primary Care is for Veterans who have complex health care needs for whom routine clinic-based care is not effective.

The program is for Veterans who need skilled services, case management and help with activities of daily living. Examples include help with bathing, dressing, fixing meals or taking medicines. This program is also for Veterans who are isolated or their caregiver is experiencing burden. Home Based Primary Care can be used in combination with other Home and Community Based Services.

Video about Home Based Primary Care

Watch the video to hear what Home Based Primary Care providers, the Veterans they care for, and their families have to say about this program.

RETURN TO: Home and Community Based Services
TOOLS for Shared Decisions

PRINT this topic
Home Based Primary Care - VA

- Primary care visits are conducted in the Veteran’s home by a MD, NP or PA
- Care management is done by a nurse practitioner, physician assistant, or nurse coordinator
- Coordination of care is done by a social worker
- Mental health services are available
- Therapy visits are available from a physical, occupational, or speech therapist
- Medication management is available
- Nutrition counseling is available through a dietician
Caring for Older Adults and Caregivers at Home (COACH)

• Innovative care coordination program at the Durham Veteran’s Affairs Medical Center in Durham, NC, USA
  – Provides home-based dementia care and caregiver support for individuals with dementia
    • Consultative support includes attention to behavioral symptoms, functional impairment, and home safety
• Participants are community dwelling veterans with dementia aged 65 and older who receive primary care in the medical center’s outpatient clinics
Rural Promising Practice Issue Brief: Caring for Older Adults and Caregivers at Home (COACH)

Executive Summary

As the United States faces an aging population, the number of individuals and families affected by dementia will continue to grow significantly. Roughly five million Americans aged 65 and older are diagnosed with dementia and this figure is expected to triple to nearly 13 million by 2050.¹

There is substantial societal cost associated with caring for individuals diagnosed with dementia including skills, maintain favorable health behavior and quality of life, and increase social support and satisfaction for caregivers.⁶

Furthermore, many individuals and families impacted by dementia have a strong preference to keep the affected loved one living at home. However, the progressive frailty, caregiver strain, and significant behavioral challenges often result in the individual being moved to a long-term care facility.⁷

To address the needs of Veterans diagnosed with
Mission Statement:

Just for Us is a collaborative community based medical program designed to improve health and sustain independence, functionality, and well-being among Durham County’s mature adults.
The Nuts & Bolts

- In-home primary care services
  - Chronic Disease Management
    - Disease education, disease monitoring, med reviews, med refills (where appropriate) cancer screening, immunizations
  - Acute visits
  - Health Prevention Education
  - Emergency Department and Hospital Follow-Up visits**

- Social Work
  - Community resources, case management

- Occupational Therapy
  - DME needs, falls reduction

** If not already being seen by Primary Care Provider, ideally within 7 days
Chronic Disease Monitoring
- Blood glucose monitoring
- Blood pressure checks
- Weight checks
- Physical exam
Welcome to Beacon Hill Village

Connect. Discover. Enjoy.

Beacon Hill Village, a member-driven organization for Boston residents 50 and over, provides programs and services so members can lead vibrant, active and healthy lives, while living in their own homes and neighborhoods.

Benefits include access to discounted providers who can help you manage your household, stay active and healthy, and serve your driving needs. Our social and cultural programs are always changing to support member interests.

TICKETS NOW AVAILABLE

BHV's 5th Annual Creative Kitchens Tour

Saturday, April 7, 2018

Click HERE for more information

Thank you to all who made the 4th Annual Creative Kitchens Tour a great success

Kitchens Tour Sponsors

Volunteers
Independence at Home Demonstration
Center for Medicare and Medicaid, USA

- 14 individual practices, including Doctors Making House Calls
- Began in 2012, ended in September 2017 (extension to 2019?)
- Conducted by the Center for Medicare and Medicaid Innovation
  - Incentive model that used home based primary care teams directed by physicians and NPs to provide chronically ill patients and those with functional limitations a complete range of primary care services in the home setting tailored to their needs
  - Designed to test whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health for beneficiaries and lower costs to Medicare. Outcomes are pending.
Senior PharmAssist
Durham, North Carolina, USA

• Mission: To promote healthier living for Durham seniors by helping them obtain and better manage needed medications, and by providing health education, Medicare insurance counseling, community referral and advocacy.

• Vision:
  – That all seniors are healthy, empowered, independent, and treated with respect.
  – Full access to coordinated health care and social services to enable a high quality of life for seniors and their families.
  – A healthcare system that is affordable, user-friendly, and cost-effective and that focuses on holistic “well care” rather than sick care.
  – Strives to be the leading pharmaceutical care model in North Carolina that honors and values older adults, and provides related preventative health services to seniors in Durham, NC.
For every $1 spent in the U.S. on medications, $1.36 is spent on dealing with medication-related problems.

We work with seniors and their providers to ensure that medicines are used as safely and effectively as possible.
Examples in Action

LONG TERM CARE PRACTICE MODELS
Program for All Inclusive Care of the Elderly (PACE)

- Comprehensive community-based care model for frail, chronically older adults with significant functional and cognitive impairment that makes them nursing home eligible.
- Started in an area of San Francisco called Chinatown in 1971 as an alternative to nursing homes in the Chinese community.
- Original name was OnLok which is Cantonese for “peaceful, happy abode.”
- Typical participants are greater than 80 years old with 8 or more acute and/or chronic conditions and are noted to have at least 3 activities of daily living dependencies.
- PACE programs have been demonstrated to improve quality of care and access to services based on need.
Senior CommUnity Care of North Carolina

Senior CommUnity Care of North Carolina is a comprehensive health care program for seniors living in Wake, Durham and select zip codes in Granville counties. Learn more.

Language Assistance Services Available
Español | 繁體中文 | Tiếng Việt | 한국어 | Français | العربية | Hmoob | Русский | Tagalog | ภาษาไทย | ရောင် | Deutsch | हिंदी | ภาษาไทย | 日本語
THE GREENHOUSE® Project

• Vision statement: “We envision home in every community where elders and other enjoy excellent quality of life and quality of care; where they, their families, and the staff engage in meaningful relationships built on equality, empowerment, and mutual respect; where people want to live and work; and where all are protected, sustained, and nurtured without regards to ability to pay. “

• Mission statement: “We partner with organizations, advocates, and communities to lead the transformation of institutional long-term care by creating viable homes that spread THE GREEN HOUSE® Project vision – demonstrating more powerful, meaningful, and satisfying lives, work, and relationships."
For over a decade, healthcare providers have trusted The Green House Project experts to help envision, create, and optimize caring homes for meaningful lives.

Their results?

The new standard in long-term and post-acute care, with national brand power, higher measurable quality outcomes, consumer demand, and caregiver satisfaction.

“Any number of people can design or build the architecture but that doesn’t bring about the revolutionary change in culture that The Green House Project provides. For us to be able to leverage the successes and failures of so many other adopters is invaluable. The Green House Project has the expertise and structure to help manage our process in a manner that gives our project the highest possibility of success.”
Household Model

Why would we ask anyone to give up home, just when they need it the most?

In the Household Model, long-term care homes adopt a person-centered approach that shapes the physical environment, organizational structure, and interpersonal relationships in ways that create an atmosphere of genuine home, while providing elders with clear opportunities to direct their own lives.

The Household Model breaks down a traditional facility or new development into households of 14-20 residents, with their own kitchen, dining room, living room and often the extra small cozy spaces you’d find in any home (den, patio, front porch).
Charles House Association
Chapel Hill, North Carolina, USA

- The mission of Charles House Association:
  - Enriching the lives of seniors
  - Supporting families caring for aging family members
  - Representing the community’s commitment to its elders

- Operates Charles House Center for Community Eldercare (day program) and Eldercare homes (primary residences)

- Eldercare Homes:
  - neighborhood based
  - house 6 residents per home
  - designed with the Household Model framework
  - includes resident and family participation
  - team approach to caregiving
  - high levels of social and physical engagement for residents
  - are a true home with privacy, dignity, and community as core values
References


• https://seniorpharmassist.org
• http://www.who.int/ageing/en/
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• https://www.ruralhealth.va.gov/docs.promise/COACH_issue_Brief_Final.pdf