Communication Helps Seniors Age in Place

Teamwork is Vital in Keeping Satisfaction High, Cost Low

The aging field is all about trends and buzz words. It seems that lately "care transitions" are the only thing we read about in journals and in the news. We all talk about "breaking down the silos" in the field of aging services. But is it just lip service?

Not to Alexian Brothers, Miami Jewish Home and Hospital or National Church Residences' InCare program. Each has taken steps to combat the problems of high hospital readmissions and provide seamless and quality transitional care.

What's the common theme in all of these programs? Communication. While they all have different methods and slightly different goals, they have been able to better develop their methods for communicating across the myriad of aging services providers to ensure that older adults have access and options to receive care where and how they want it.

PACE in Florida

Dan Brady, Ph.D., executive director of community-based services at Miami Jewish Home and Hospital, is in charge of the Program for All-Inclusive Care for the Elderly (PACE) program, called Florida PACE, and he knows all about eradicating silos. The Miami Jewish Home PACE is the oldest and largest PACE program in Miami-Dade County, Fla. It currently has 179 individuals enrolled. Dr. Brady and his staff recognized a tremendous need for PACE services in the nearby town of Hialeah, Fla., where residents are primarily Hispanic. In the spirit of collaboration, Miami Jewish Home joined with the housing authority of Hialeah and is opening its second PACE program, with an expected initial enrollment of 140 participants, many of whom live in federally subsidized Section 202 properties. Brady cited Miami Jewish Home's mission to serve all older adults in need as the motivation behind this partnership and new venture to reach an underserved population.

Florida PACE has discovered that one of the main communication breakdowns occurs when an individual is discharged from the hospital. It found that a good relationship (if there is any at all) between home care workers, meal program providers, personal care service providers and members of the hospital discharge team can be vital. Brady stressed the importance of communication between the members of the medical care team (doctors, pharmacists, nurses, social workers) and those on the "front lines" who are actually providing post-acute care. He noted that in today's economy, more and more family caregivers are unable to miss work to provide care for their loved ones, so more than ever before, families are relying on home health care and personal care workers to nurse their loved ones back to health.

Brady repeatedly pointed to the non-stop communication between provider types as one of the main reasons for the PACE program's success in providing quality and seamless transitions in care. He said that the program's physicians regularly consult with inpatient care providers when a program participant is admitted to the hospital or to a skilled nursing facility. Also, upon discharge, the social worker at Florida PACE receives a copy of the discharge plan and is able to monitor medications and oversee this important transition.

Said Brady: "PACE plays the role of the coordinator of care across transitions. PACE serves as the 'medical home' in many cases." He cited medication management, especially from an inpatient facility to an outpatient setting, as one of the biggest factors in a quality transition.

So, with all of this increased communication, is it working? According to Brady, a study conducted by the organization showed that, "Florida PACE had 175 hospital admissions during the 2008 calendar year. Twenty-six individuals , or 6.7 percent, were readmitted within 30 days, but only nine, or five percent, were readmitted with

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the same diagnosis."

The Florida PACE's main goal is to provide "minimal disruption in people's everyday lives, even as their care needs change." Through constant communication along all lines of care types, Florida PACE is able to lower its participants' rates of hospital readmissions, which saves them money and saves the government money, besides drastically improving the lives of older adults.

Alexian Brothers Live at Home

The Alexian Brothers' Live at Home program seeks to help another segment of the population that is prone to falling between the cracks. A lot of attention is paid to people who have money and to those with extremely limited resources, but what about the people with care needs in between? The Live at Home program is similar in structure to a continuing care retirement community, but this program has many modifications that make it flexible and more affordable to people who may not be able to afford typical continuing care entrance and monthly fees. The Live at Home program currently has a membership of 219 members and each member receives an annual wellness assessment and individualized care plan created by a care manager (currently there are three, a nurse, social worker, and a physical therapy assistant). They have weekly care conferences to discuss the status of their members with their interdisciplinary team. If a member is admitted to the hospital, the care manager visits the person in the hospital and works with the hospital discharge planner to determine the services needed after discharge. The program has found that they will frequently need to increase some of the support services until the member returns to pre-hospitalization status, but that the benefits outweigh the costs involved.

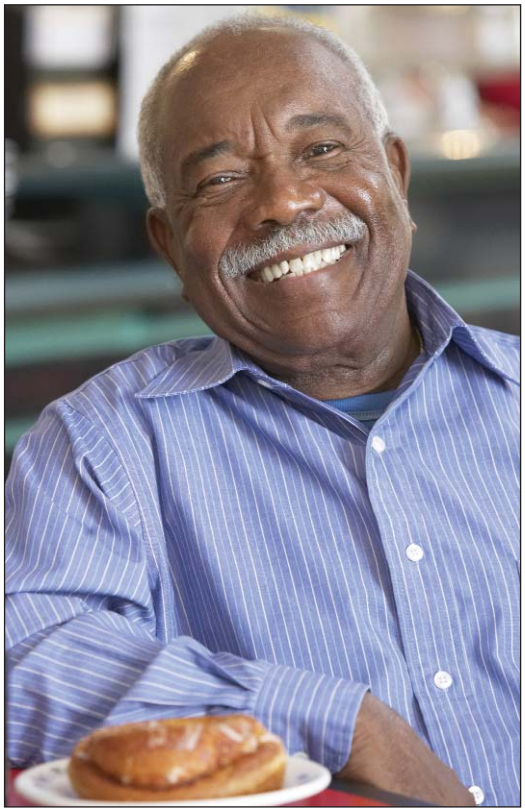
Also, in order to attract more people to the program, they have modified the traditional continuing care model by offering a rental option to participants needing housing, an option that allows a portion of the entrance fee to be refunded to the family after the participant passes away, and different packages of care (gold, silver, and bronze) that help individuals with long-term care insurance receive home and community-based care that otherwise would not be covered under many insurance policies.

A recent actuarial study conducted by the consulting firm Third Age found that, from the Live at Home program's inception in 2002 until 2008, it has achieved an important goal of reducing institutional-based care. Third Age found that at the end of 2008, seven members in the Live at Home program used facility-based care, while a continuing-care population of the same age and gender mix had approximately 25 members using facility-based care.

InCare's Answer

Both Miami Jewish Home and Alexian Brothers provide superior transitional care for older adults living in their own homes, but what about a program designed particularly for older adults who are living in federally subsidized properties? InCare, an affiliate of National Church Residences, has the answer. According to the director of the InCare program, Terry Allton, the goal of helping affordable housing residents age in place is logical given that National Church Residences has 300 independent housing communities in 28 states and Puerto Rico, and 80 percent of that

housing is made up of federally subsidized Section 202 facilities. The InCare model focuses on the service coordinator in the housing facility as the coordinator of care. Almost 89 percent of National Church Residences' Section 202 properties have a service coordinator, an incredibly high percentage compared to some studies that cite the national average of 20 percent. Allton states that another reason to focus on residents of Section 202 facilities is because these older adults consume a high number of Medicare and Medicaid dollars every year. Their goal is to see how many silos they can bring together under one umbrella. So far, they have brought together homemaker services, skilled nursing facility services, therapy services, hospice, and adult day care services. This allows InCare to offer a menu of services to residents who want to age in place, but have trouble navigating through the confusing and fragmented long-term care services and support world. With the service coordinator serving as the "hub," coordinators work with a nurse liaison and the "InCare navigator," a master's degree social worker who looks at all available resources in the community that could assist the older adult resident.



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InCare is currently in operation in central and southern Ohio and has a combined total of 650 people in the program. Success stories include a woman who suffered a stroke and through the work of her service coordinator was able to return to her apartment after her hospital stay instead of spending weeks in a skilled nursing facility. For this woman, and many others, the outcome was great in terms of cost as well. The cost of this older adult returning to her apartment was much less than it would have been for her to go to a nursing facility.

InCare has conducted extensive research on its program in order to evaluate whether it is making a difference in saving money and in improving participants' lives. It collected information from 183 program service coordinators for the period covering September 2008 through August 2009. These service coordinators serve 15,123 housing units with a total of 16,276 residents, and 66 percent of these residents are considered to be "at-risk" or "frail" (as determined by their ability to perform ADLS, or activities of daily living). The service coordinators assisted residents with seeking additional resources and found that their assistance prevented 2,015 hospital admissions; 2,068 nursing home placements; 1,833 emergency 911 calls and 1,671 emergency room visits.

Miami Jewish Home's Florida PACE, Alexian Brothers' Live at Home, and National Church Residences' InCare program are all providing quality and seamless transitions of care to a population that is in dire need of this coordination. As older adults' needs change, their desire to remain in their own homes and communities does not. These organizations are able to break down the silos that have plagued aging services for far too long. ■

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