

WHCoA Post-Event Summary Report

Name of Event: Geriatric & Extended Care Leadership Independent Aging Event

Date of Event: June 8, 2005

Location of Event: The Boston Park Plaza Hotel
Boston, MA

Number of Persons attending: 100

Sponsoring Organization(s): The Office of Geriatric and Extended Care, Department of Veterans Affairs, Washington, DC

Contact Name: Paula Hemmings, RN, MSN Geriatric & Extended Care Line Director, VISN 2

Telephone Number: (518) 626-7304

Email: Paula.Hemmings@med.va.gov

Workgroup 1: Palliative Care and End of Life Needs for the Aging Population

WHEREAS there is lack of definitional clarity and understanding of the terms and concepts of “hospice”, “palliative” and “end of life care” thus creating barriers to the provision of effective end of life care;

WHEREAS the success of technology and medical advances often result in a long and unpredictable trajectory of chronic illness such that end of life is often measured in years;

WHEREAS the affirmation of life and living includes addressing the unique mix of patient and family needs to relieve suffering, promote autonomy and maintain independence at end of life;

WHEREAS palliative care is often applied solely to end of life care in spite of the widely accepted goal for palliative care to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease;

WHEREAS the urgent challenge of end of life care will grow more serious over the next three decades as the population of seniors more than doubles and more than 70% of those who die each year will be age 65 or over;

WHEREAS the urgent challenge of end of life care includes a significant number of veterans which account for one out of every four deaths in America;

WHEREAS surveys show that most Americans would prefer to die at home, in 2003 for all Americans who died, 75% died in a nursing facility or hospital because of a lack of non-institutional alternatives;

WHEREAS disparities in access to end of life care result in the under representation of certain populations receiving quality end of life care;

WHEREAS care at end of life is often fragmented among providers and settings, leading to a lack of continuity of care and impeding the ability to provide high quality, interdisciplinary care;

WHEREAS: persons who are eligible for more than one payer (Medicare, Medicaid, Veterans Administration and/or private payers) are subject to unnecessary disruptions in the continuity of end of life care because of legislative and administrative limitations;

WHEREAS the design of the current Medicare Hospice Benefit limits the availability of the full range of interventions needed by many persons at the end of life;

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to support policies that:

- A. Eliminate legislative and regulatory barriers and gaps in end of life care coverage for specific populations such as:
 - i. The legislative barriers to allow improved collaboration and coordination of benefits for veterans dually eligible for end of life care under the Medicare Hospice Benefit and the VA.
 - ii. The arbitrary time frame for certification of life expectancy less than 6 months to receive the Medicare Hospice Benefit;

- B. Develop a systems approach to integrate the delivery, financing and administration of end of life care services across settings and payers
 - i. Increase access to hospice and palliative care through enhanced training of acute and long-term care physicians and staff about palliative care concepts, enhanced education of the public on the availability of end of life care alternatives and improved funding to promote well informed health consumers through open discussions with their providers.
 - ii. Promote and establish funding for the development of non-institutional alternatives to care at end of life;
 - iii. Focus the provision of end of life care on the needs of the aging patient population through; 1) enhanced collaboration of experts in geriatrics and palliative care, 2) feedback provided by the institution of a uniform satisfaction measures across care venues and payers and 3) elimination of legislative barriers to promote

access to quality end of life care which meets the needs of an aging population across venues and payers

Workgroup 2: Healthcare Workforce: Strengthen recruitment and retention of the long-term care (LTC) workforce for care of the elderly

WHEREAS approximately 15% of the nation's elderly requires geriatric care;

WHEREAS interdisciplinary teams have been demonstrated to be key to effective care of elderly persons with complex, chronic disabling conditions, addressing clinical, psychosocial and environmental concerns; (Rubenstein LZ, et al. Effectiveness of a geriatric evaluation unit. A randomized clinical trial. *N Engl J Med* 1984;311:1664-1670) (Tsukuda R. Interdisciplinary collaboration: teamwork in geriatrics. In: RD, Cassel CK, Sorensen LB, Walsh JR, editors. *Geriatric Medicine*. 2nd edition. New York: Springer-Verlag; 1990. p. 668-75)

WHEREAS interdisciplinary team care that is longitudinal and maintains patient-provider relationships over time has been demonstrated to improve care, yield higher patient satisfaction, improve quality of life ratings, result in higher caregiver higher satisfaction, (S Hughes, F Weaver et al, *JAMA* 2000: 284; 2877) and reduce hospitalizations and cost (Edes T, Kendall S, *J Amer Geriatr Soc*. 2005;53:s207)

WHEREAS despite the demonstrated benefits of geriatric care, there is a major and worsening shortage in the geriatric work force for all professions involved in the healthcare of the elderly, including nurses, social workers, rehabilitation therapists, pharmacists, psychologists, dietitians and physicians; (Public Policy and Aging Report, vol 13, no 2, Spring 2003)

THEREFORE, BE IT RESOLVED by the 2005 WHCOA to promote policies that

- A. Improve recruitment and retention of LTC workers through incentives that include:
1. Management practices that honor and respect the individual needs of the LTC worker, including flexible work hours, child and elder care, and commensurate benefits for part-time work.
 2. Support for full-time and part-time LTC workers that includes retirement and healthcare benefits as well as competitive salary.
 3. Longitudinal continuity of care relationships with patients/families
 4. Outcome-based incentives for home and community care
 5. Mid-career training and mentorship opportunities
 6. Advancement, recognition, status and image of LTC workers, promoting their added value to the organization and society
 7. Promoting interdisciplinary teams: training and work environment
 8. Working conditions to include technology support
 9. Analysis and redefinition of roles and positions

- B. Encourage healthcare professionals to pursue geriatric skills training and follow geriatric care principles in their practices, through incentives that include:
 - 1. Competency standards in geriatric assessment, care coordination services, and other geriatric skills
 - 2. Scholarships and loan forgiveness for those who pursue training in geriatric care
 - 3. Reimbursement structure with fair and adequate compensation for health care professionals to learn and utilize the requisite skills, and spend the time necessary to provide effective, coordinated care of the elderly with complex chronic disease.

- C. Promote recruitment of health professions faculty through incentives that include:
 - 1. Advanced degree scholarship programs for geriatric and gerontologic studies, instituted by the Bureau of Health Professions;
 - 2. Mid-career faculty development scholarships oriented to geriatric education;
 - 3. Loan forgiveness to health care professionals who pursue an academic career in geriatrics.

Workgroup 3: Care for the Older Patient with Mental Illness

WHEREAS older persons with Mental Illness and co morbid conditions are at greater risk for institutional, expensive acute and emergency care and

WHEREAS current financial incentives preferentially support higher cost institutional care over community-based alternatives

THEREFORE, BE IT RESOLVED THAT

Payment reform be enacted that promotes effective and lower cost coordinated community care alternatives

WHEREAS older individuals with Mental Illness and co morbid conditions are at greater risk for under diagnosis and treatment of their Mental Illness and fragmentation of care generally

THEREFORE, BE IT RESOLVED THAT

A. A broad educational campaign of consumer and providers be undertaken to promote “share-decision making” that leverages resources in the community to raise expectations for the provision of quality Mental Health services.

B. Financial Incentives are adequately provided that insure screening and appropriate referrals for patients with mental illness in and from Primary Care settings and enhance efforts at sharing a unified medical record and facilitated communication and coordination of care across treatment settings, programs and agencies

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Workgroup 4: Assisted Living and other Non-Institutional Alternatives for Extended Care

WHEREAS more Americans are living longer and therefore there is a growing number of aged individuals passing the point in their lives at which they become dependent on others for assistance with daily living activities; and

WHEREAS a rising number of aged individuals requiring such assistance is expressing the preference to receive those services in their home or in other non-institutional settings in the community for as long as possible, in order to retain control over their personal choices and to optimize their quality of life; and

WHEREAS a broad array of non-institutional forms of extended care, including Assisted Living, Medical Foster Care, All-Inclusive Care [“PACE”], Homemaker/ Home Health Aide, Adult Day Health Care, Skilled Home Nursing, Respite Service, Home Telehealth and Geriatric Case Management, has been demonstrated in numerous settings and for a wide range of populations to have the potential to significantly enhance quality of life, prolong independence, reduce hospital days of care and emergency room visits, and improve caregiver health and well-being, at a cost no more than and in many cases significantly less than nursing home services; and

WHEREAS the U.S. Supreme Court’s Olmstead decision underscored the fact that “the right to choose” is a recognizable right of all individuals living with disabilities; and

WHEREAS our own public healthcare financing system inadvertently but undeniably promotes a form of discrimination in that it generously supports institutionally-based long-term care, but does not equivalently or uniformly promote home and community-based alternatives for extended care, thereby *de facto* reducing available options for a substantial proportion of people who need or will need services along that continuum of care choices; and

WHEREAS the increased average age and heightened level of infirmity of the residents of American nursing homes has compelled those institutions to become increasingly focused on the multiple serious health needs of their clients, and less on their social and recreational ones; and

WHEREAS the number of nursing home beds in the United States has increased from approximately 1.5 million in 1990 to over two million in 2005, while the nursing home bed occupancy rate has declined from 85% in 1990 to barely 70% in 2005; and

WHEREAS the nursing home industry employs over 2 million Americans, represents over \$140 billion in real property, and posts annual revenues of over \$70 billion annually, and therefore represents significant social will for, and accounts for understandable governmental momentum in favor of, continued support for this form of care;

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to recommends that a single agency or interagency group of the federal government must be charged with, and financed to assume, the responsibility for developing and implementing a coordinated program of federal, state, local, profit, non-profit and faith-based initiatives. The focus of this effort will be on maximizing consumers' choices for extended care services in urban, rural, and suburban settings through vocational re-training of LTC professionals, architectural conversion of existing spaces, business and labor incentives to drive change, systems for third-party payer participation, facilitated public/private collaborations, public financing, transportation services, and consumer and stakeholder education. Expanded volunteerism and ombudsman services will be supported to further expand the range, fill the gaps in, and bring into the reach of most citizens the full continuum of equitably-supported, non-institutional alternatives for extended care. This expanded provision of safe, minimally restrictive extended care choices will be effected even as the existing nursing home industry and its workforce are empowered to retain their partnership roles in long term care as they evolve and strive to keep pace with the expanding range of extended care options increasingly demanded by aging consumers.

Workgroup 5: Chronic Disease Management of Frail Elderly Patients

WHEREAS the fastest growing part of the population is over 85, and need more ADL assistance, and have more chronic diseases; and

WHEREAS the healthcare system is currently not organized to provide comprehensive care to complex patients with chronic medical and psychological illnesses; and

WHEREAS the *Crossing the Quality Chasm* Institute of Medicine report recognized that chronic disease management is an important component of the health care system that needs to be improved; and

WHEREAS the VA has expertise in managing these patients through the application of case management approaches; and

WHEREAS new technologies hold promise for improving care of patients with chronic diseases and the VA has invested in these technologies;

THEREFORE, BE IT RESOLVED THAT:

1) The federal government form a chronic disease management task force that brings together federal agencies that have chronic disease management initiatives, including but not limited to HHS (CMS, CDC, HRSA, etc), VA & DoD. The goals of the task force would be to:

- a) Identify federal agency best practices and effective models of case and disease management for frail older adults.

- b) Support expanded demonstration programs and research and evaluation of ongoing programs within the federal government.
 - c) Support educational initiatives to improve the knowledge of professionals in the use of chronic disease management tools.
 - d) Identify and support the use of telehealth technologies in the implementation of chronic disease management programs.
- 2) An Institute of Medicine report on chronic disease management be commissioned that would bring together representatives of health care providers, insurers, employers and other health care payors, federal, state and local government, and academic experts to:
- a) Identify best practices and effective models of case and disease management for frail older adults.
 - b) Support expanded demonstration programs and research and evaluation of ongoing programs.
 - c) Support educational initiatives to improve the knowledge of professionals in the use of chronic disease management tools.
 - d) Identify and support the use of telehealth technologies in the implementation of chronic disease management programs.
- 3) The federal government reaffirm its commitment to supporting the necessary building blocks to assure access to needed services for older adults with chronic illnesses, including at a minimum, transportation systems, health care systems, mental health programs, caregiver education and support, information technology systems, and affordable housing.