COLLEGE OF MEDICINE TUCSON
Center on Aging

Banner Health

TEAM CARE: IMPACTING OUR COMMUNITY'S HEALTH

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OBJECTIVES

1. Recognize what is important to individuals as they age and what matters to aging communities as a whole.
2. Describe benefits of team models of care in caring for older persons.
3. Review national, regional and local best practices in caring for older persons.

HOW THE AIRLINE INDUSTRY TACTICS COMPARE

AIRLINE INDUSTRY

- Who assists you during your trip? Airline attendant.
- Unaccompanied MINOR policy? Yes. Any similar SENIOR policy? No
- What is their SMOKING POLICY? "At the penalty of law, no smoking…" and "It is a federal offense to tamper with or disable smoke detectors…"

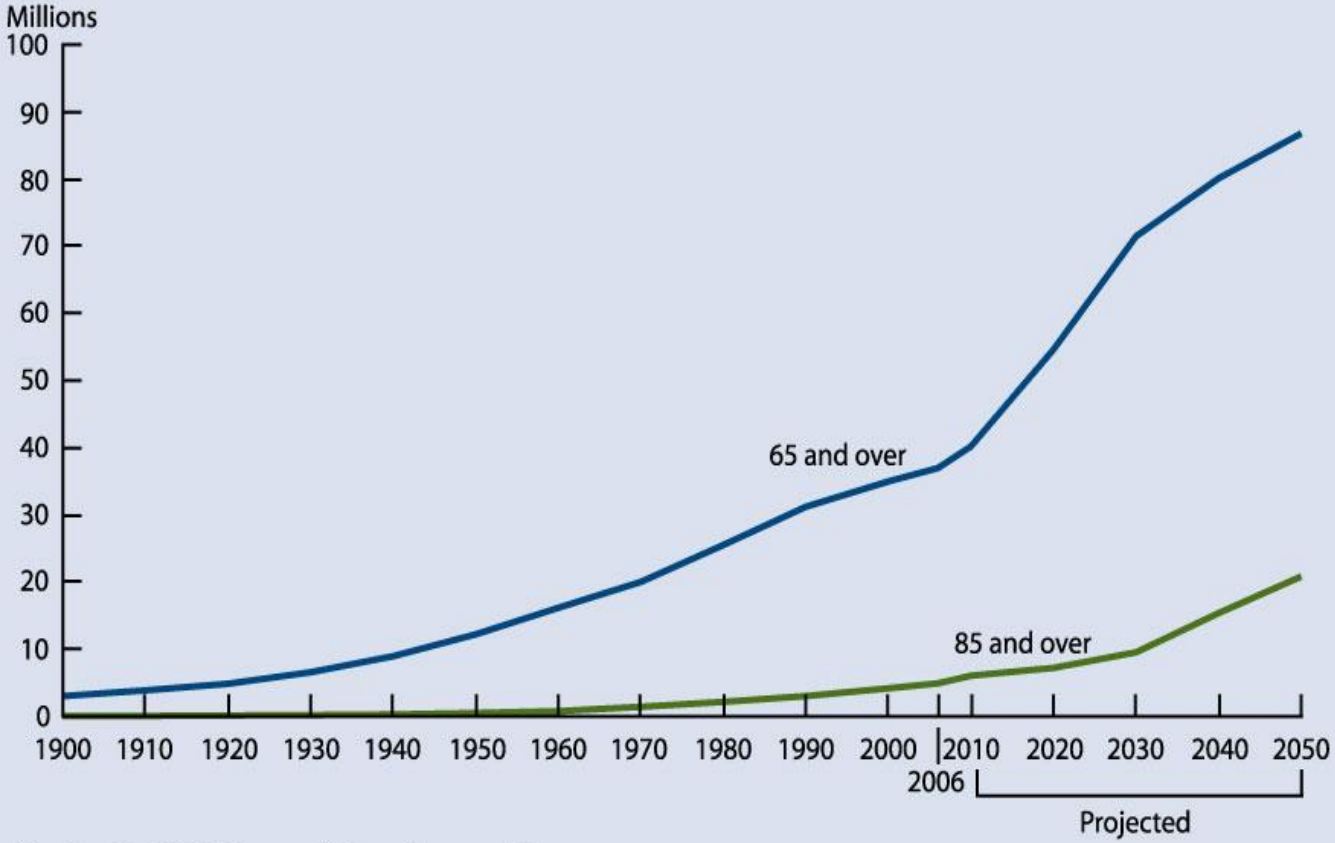
HEALTH CARE INDUSTRY

- Who assists you during your trip? Varies, maybe no one.
- Work with the family/caregiver or other care team members? Important in care for all ages.
- Patients have the right to make their own health care choices. Smoking cessation becomes a challenging issue and an individual choice.

WHY THIS MATTERS:

- Aging populations
  - Most aged counties in Arizona
- Meeting the needs and wants
- Quality of care
- Costs of care
- Transitions of care and other issues of connecting

Number of people age 65 and over, by age group, selected years 1900–2006 and projected 2010–2050



Note: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census, Population Estimates and Projections.

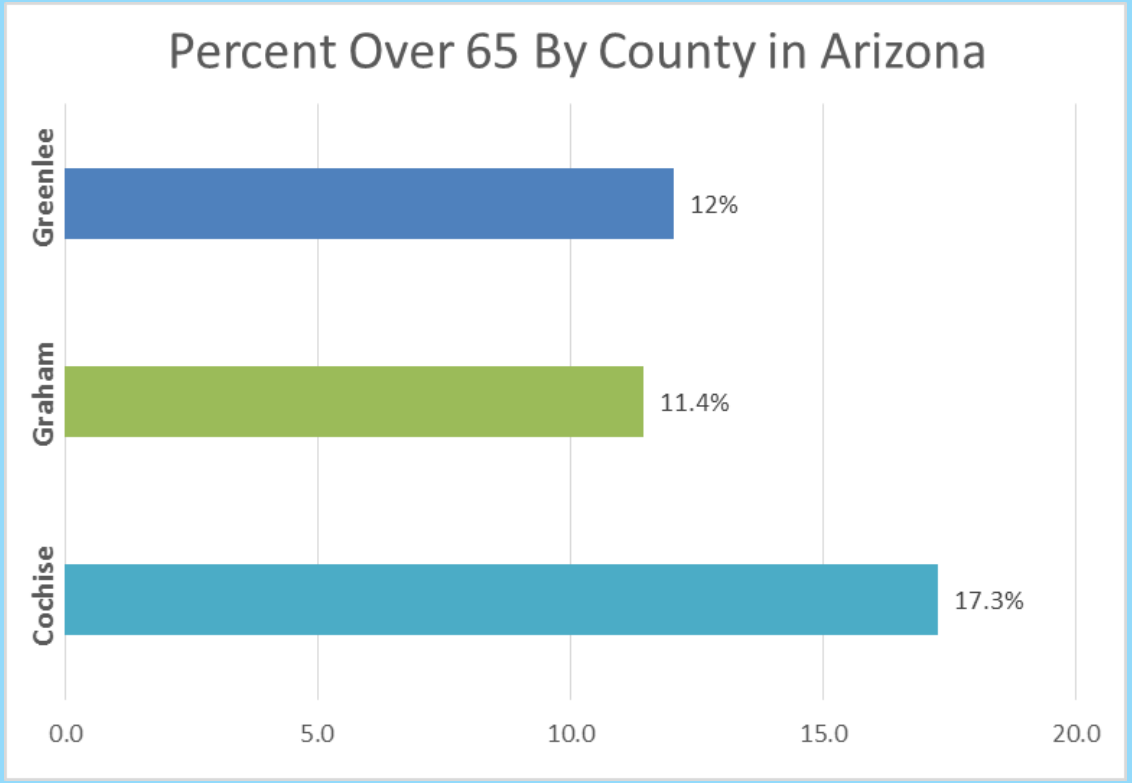
AgingStats.gov Federal Interagency Forum on Aging-Related Statistics 2008

WHY THIS MATTERS:

- Aging populations
  - **Most aged counties in Arizona**

MOST AGED COUNTIES IN ARIZONA

- Nationally, Arizona is 22/50 in percentage of over 65 of the 50 states—and has 13% 65 years and older.
- In Arizona, the La Paz (32.6%) then Yavapai (24.1%), Mohave (23.3%) then Gila (23.2%) have the oldest populations. Cochise at 17.3% is next or 5/15 in % oldest. Santa Cruz has 13.1%.



Source: 2010 U.S. Census

WHY THIS MATTERS:

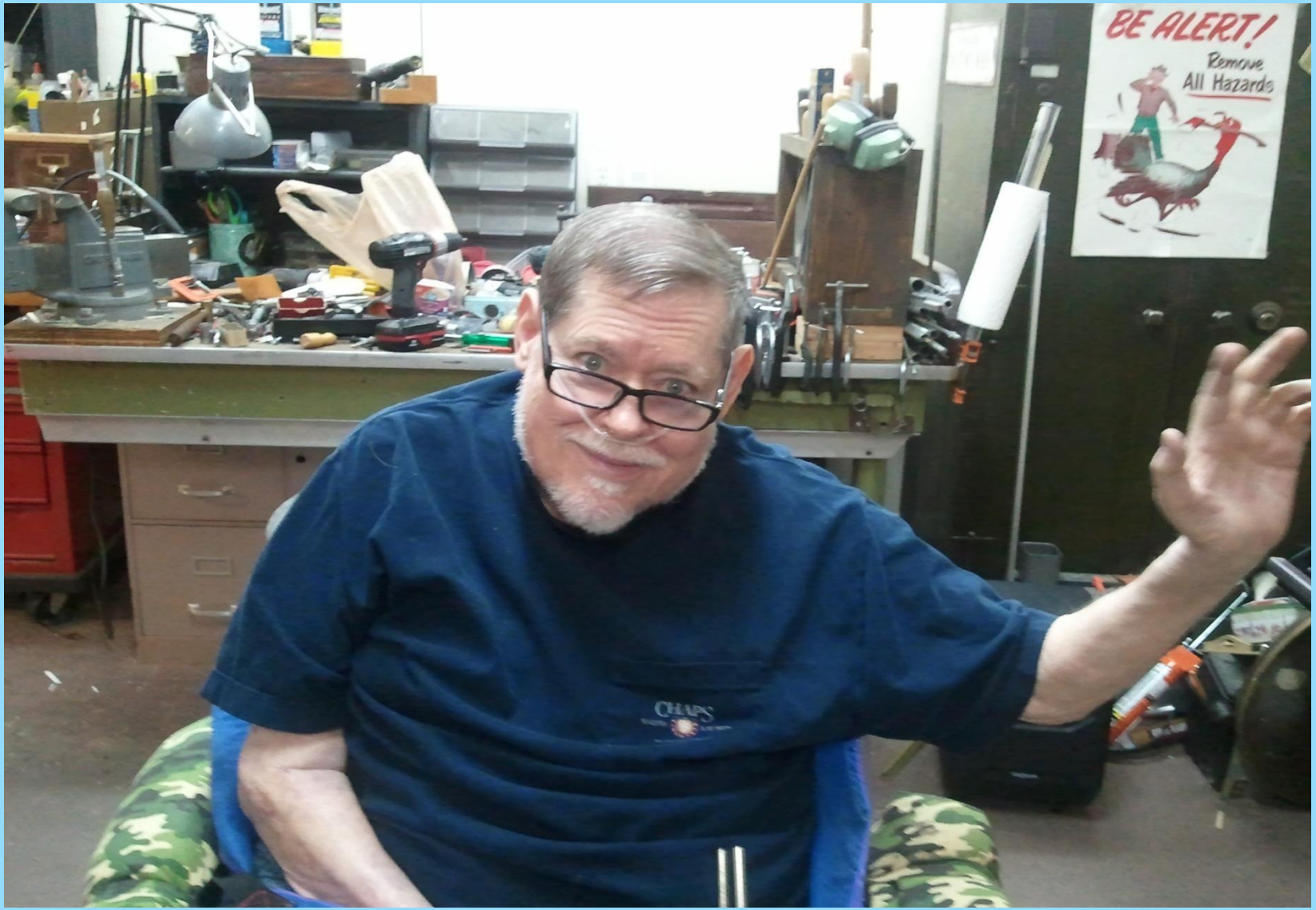
- Aging populations
  - Most aged counties in Arizona
- **Meeting the <u>needs</u> and <u>wants</u>**

MEETING THE NEEDS

- Basic necessities of living:
  - Food
  - Clothing
  - Shelter
  - Transportation
- Health care needs:
  - Physical health decline and increasing care needs
  - Cognitive health decline and increasing care needs
- Health and well-being of caregivers

MEETING THE WANTS

- Person-Centered Care
  - Preferences of the individual as to where, when, and how to receive care.
  - Right to refuse, accept and even change their mind.
- Goals of Care
  - Ongoing discussions during acute and chronic illness events about active/aggressive treatment, function-focused/rehab care, and/or palliative/comfort focused care goals. Advance directives fit here.
  - Right to refuse, accept and even change their mind.
  - Surrogate decision-makers important.



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- **Quality of care**

QUALITY OF CARE: QUALITY DEFINED

"Doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."

Agency for Healthcare Quality and Research (AHQR)

WHY THIS MATTERS:

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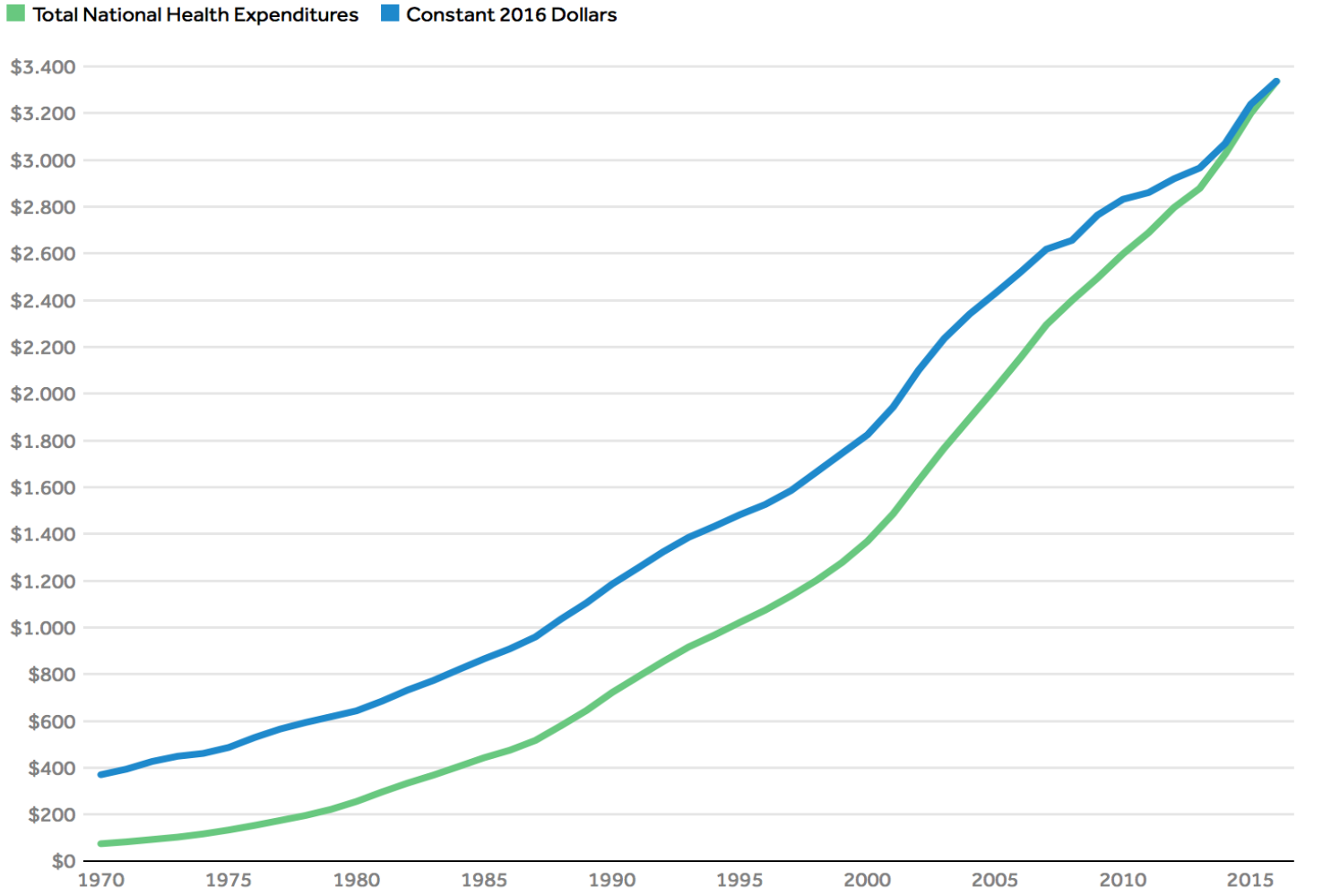
- **Costs of care**

Total national health expenditures, US $ Billions, 1970-2016



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group • Get the data • PNG

Peterson-Kaiser
Health System Tracker

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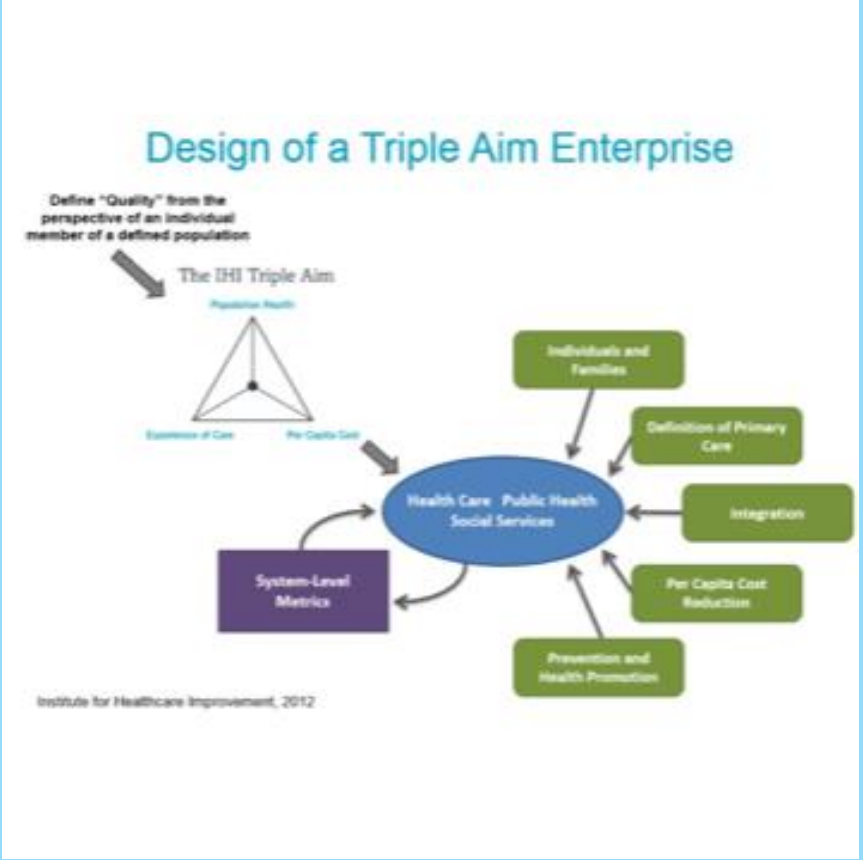
COSTS OF CARE: THE TRIPLE AIM

- The simultaneous pursuit of improving the patient experience of health care, improving the health of populations, and reducing the per capita costs of health care.
- The Triple Aim is a single aim in three dimensions.



COSTS OF CARE: THE QUADRUPLE AIM

What is the Quadruple Aim of Medicine?

"Yet physicians and other members of the health care work force report widespread burnout and dissatisfaction…"

Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

-T. Bodenheimer 2014 Annals Family Med

MEETING THE NEEDS AND WANTS

- Achieving specific health outcomes of at-risk older populations requires the combined skills of a wide range of professionals operating as a team.
- Models include medical-home models, home-based primary care, Medicare hospice care benefit. VA has some of the best data!
- Expanded access to care and ease of access become more important.

WHAT PEOPLE WANT

- Where do people want to live?
  - In their own homes
  - Older persons relate their quality of life to being able to care for themselves and their home.
- Where do people want to die if terminal?
  - Many in their own homes
  - Most do not want to be a burden to family at the same time
- Where do they die?
  - Hospitals and other institutional settings vs home

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TRANSITIONS OF CARE ISSUES

- Medical care transitions are difficult for older persons
- Typical transitions include:
  - Hospital to home
  - Emergency room to home
  - Hospital to skilled nursing stay
  - Skilled nursing stay to home
- Medication errors or compliance issues are common and can be DANGEROUS
- New billing codes to encourage Transitional Care by primary care providers exist
- Communication is key and efforts now focus on improving this
- Community Paramedicine has seen local successes in Sierra Vista

MODELS OF CARE: THE IDEAL HEALTH TEAM

- Traditional team is Doctor and Nurse.
- Modern team may include Nurse Practitioner, Physician Assistant, Social Worker, Dietician, Medical Assistant, Case Manager, Community Health Worker, Physical/Occupational/Speech Therapists, Pharmacist, support staff, paramedics/EMTs, parish nurses, others.
- Traditionally, only providers (doc/NP/PA) have received reimbursement for the work they do. New payment models allow capitated payments that can support other team member salaries.
- New billing codes under Medicare allow billing for non-face to face care called Chronic Care Management and may be performed by providers and other team members.

WHAT CAN WE DO TO BE HEALTHY?

SIMPLIFIED:

- JUST BREATHE
- JUST MOVE
- ADDRESS PAIN
- CONNECT
- TALK TEAMS

JUST BREATHE

- Transfer of gases—oxygen (O_2) in and carbon dioxide (CO_2) out
- Relaxation
- Cardiovascular health
- Brain health
- Importance of SLEEP/SLEEP DISORDERS like apnea causing health effects

FRAIL SCALE

- F___atigue
- R___esistance (ability to climb 1 flight of stairs)
- A___mbulation (ability to walk 1 block)
- I___llness (> than 5 major diagnoses)
- L___oss of weight (>5% in past 6 months)

- >/=3 = Frail 1-2 = Pre-Frail 0 = Robust

The FRAIL Scale, Woo J et al JAGS 2012

JUST MOVE

- Benefits to physical and cognitive health
  - Osteoarthritis
  - Memory
  - Bowel health
- Reducing falls
- Mental well-being
- Weight management
- Increase pain tolerance
- Increase reserve to handle coming insults

EPIDEMIOLOGY OF CHRONIC CONDITIONS IN LATER LIFE

	Millions
Chronic pain	10-24
Diabetes	12
COPD	7
Heart Failure	6
Parkinson's disease	2

ADDRESS PAIN

- PHYSICAL EMOTIONAL SPIRITUAL
- These three can intertwine and influence the others
- Non-pharmacologic options KEY; care with use of narcotics
- ACEs (Adverse Childhood Events) are common in chronic pain in adults
- Focus on not only on NUMBING as the goal but on being FUNCTIONAL
- Improve armamentarium of coping and management strategies available to each individual with pain issues

CONNECT

- For the individual:
  - Use your brain; connect with your world
  - Stay as active as can; use it or loose it
  - Use your people-skills/connect with and care about others
  - Avoid social isolation: causes decreased mood and memory and increased psychosis/hallucinations
  - Talk about your wants and needs; complete advance directives
- For the community:
  - Connect the care to meet the NEEDS and WANTS of the older people in your community

TALK TEAMS

- Key point –it is a good design, to have a team, to provide the best care in the best way

For the team to function well, it is necessary to have:

- Access to all the parts—nothing on back order!
- All the parts are usable – in good working order (trained/maintained)
- All the parts fit and can work together
- They together function better than one individual going it alone

Need to:

- Advise patients and families to recognize the team approach. It is different but need everyone to recognize the other team members help the providers endure!

SUMMARY

- Caring for the aging population requires innovative models of care to include ones where teams are used to enhance the care.
- Southeastern Arizona is well-situated with community support and visionary leadership to meet the future care needs of those aging here.
- People connecting with people throughout the aging years is key to healthy aging in any community.