Frail older patients consume a significant and growing share of medical resources, yet the care received by these patients can be less than satisfactory. As our population continues to age, the number of high-cost, high-need older adults will grow, stressing already limited public and private resources.

On December 10, 2015, the Minnesota Leadership Council on Aging convened 88 older adults and caregivers along with leaders in health care, long-term care and community-based services to discuss solutions to this pressing issue. Participants focused on ways to integrate health care with social services and other supports to meet our nation’s triple-aim goal for healthcare: better outcomes, better patient experience and lower cost.

**CRITICAL FACTORS THAT COMPLICATE CARE FOR FRAIL OLDER ADULTS**

- **Multiple chronic conditions**
  - Thirty percent of Medicare beneficiaries account for 80 percent of the costs.

- **Dementia and mental illness**
  - These issues complicate care plans and service needs.

- **Transitions of care**
  - Without coordination, transitions create risk and increase complications.

- **Non-medical roadblocks**
  - Isolation, unsafe environments or little access to transportation contribute to poor health outcomes.
Themes for Integration

Summit participants generated the following themes for integration:

1. Embed a culture of person-centered care; include caregivers in decision making
2. Redesign financing systems (payment reform)
3. Communicate across sectors
4. Empower single care coordinator/navigator
5. Redesign delivery systems
6. Educate providers
7. Foster notion of individual and community responsibility and capability
8. Create structures that promote and implement change

Our imperative is to move from fixing cracks in systems to creating innovations that effect large-scale change.

1 Embed a culture of person-centered care; include caregivers in decision making

Person-centered care demands that the individual controls the type and method of care and services provided. Both philosophical and policy changes are required, such as:

1. Empower people to make informed decisions about their care and services by ensuring they have access to the information they need.
   a. Ensure that providers initiate conversations with patient/consumer about options for care and services.
   b. Expand 24/7 access to information.
   c. Provide information in languages and formats accessible to all.
2. Proactively identify decision-making processes and plan for advanced care.
   a. Ensure people identify important decision makers in their health and social care.
   b. Include and empower caregivers in making care decisions.
   c. Advocate for all patients/consumers to have advance care directives.
3. Support caregivers who serve as advocates and care navigators across sectors.
   a. Provide funding for caregiver services that relieve burden, stress and burnout.
   b. Support flexible work hours by employers, Family and Medical Leave Act policies, and education about eldercare.
2 **Redesign financing systems (payment reform)**

Sources of funding and payment drive the structure of the current system, producing a siloed network of sectors and systems that lack a coordinated approach to health and social needs. Funding may pay for services that are not needed and may not be available for needed services.

1. Establish (and agree upon) a framework of important elements of care as first step in payment reform. The framework may include:
   a. Authorizing payment for care within the community outside the health care system.
   b. Optimizing and leveraging existing resources where applicable.
   c. Considering population-specific needs.
   d. Providing person-centered care.

2. Realign Medicare payments to pay for all services—institutional and community based.

3. Develop an ongoing payment model for health information exchanges.

3 **Communicate across sectors**

Communication across sectors is inefficient and at times ineffective resulting in confusion and duplication of services. Communication does not necessarily require a merged record system. However, recommendations from the Summit point to a patient-controlled record that can be shared across providers.

1. Support information exchanges among medical providers, social services, pharmacy, etc.

2. Put the patient in control of personal health records that can be shared across systems.

4 **Empower single care coordinator/navigator**

An older adult being discharged from the hospital can have multiple people designated to help navigate systems. These can include a case manager from the county, a service coordinator through a health plan, a social worker in transitional care, a discharge planner from the hospital, a social worker with a community-based organization, etc. In order to effectively navigate across systems, empower a single care coordinator/navigator that has authority and knowledge of all systems and knows the individual and family.

1. Provide navigator/care manager to all seniors at target points.

2. Ensure navigator/care manager is empowered and has authority.
Redesign delivery systems

Significant barriers exist to cross-sector person-centered care. At the same time, individual sectors are transforming themselves to meet these obligations (Affordable Care Act, Olmstead, CMS HCBS ruling, etc.). Systems should capitalize on these existing initiatives to support person-centered service delivery across sectors.

1. Create a sense of urgency for change in ineffective systems.

2. Establish a value proposition for Long-Term Services and Supports (LTSS) (for example, integrated care can prevent readmissions, improve quality, etc.).
   a. Clarify how use of the full system produces better health care outcomes.
   b. Recognize that LTSS excel at prior care planning, care navigation assistance, education and support, regular, ongoing relationship, etc.

3. Agree on a framework for high-risk elder clients.
   a. Establish common language.
   b. Embrace a social model for care rather than just a medical model.

4. Identify and replicate successful models where sectors are integrated.

5. Establish new models where none exist.
   a. Complete decentralization.
   b. Develop a pace-like model for MN.
   c. Develop option and barriers for housing for seniors.
   d. Address gaps in hearing, vision, dental/oral care.
   e. Foster community-based wellness programs for seniors.
   f. Change Medicare’s annual wellbeing check to include broader social connections and community-based services.
   g. Promote telemedicine.

6. Address gaps in services for rural Minnesota.
6 Educate providers

Providers often become highly specialized within their sectors but less so across systems. Shifting to a more integrated system requires providers to better understand services across the spectrum.

1. Better educate across sectors with focus on transitions and solutions to problems that arise as a result of coordinated, complex care. Include education for long-term services and supports providers about health care systems/trends.

2. Commit to develop inter-professional programs for geriatrics.
   a. Developing workforce solutions (recruit, retain, etc.).
   b. Encouraging cross-team and inter-professional interactions.

7 Foster notion of individual and community responsibility and capability

Aging is both an individual and community phenomenon and, as such, solutions to poor, integrated care should be both individualized and community based. Older adults and caregivers have a role in being informed consumers. Providers have a role in assuring competent, geriatric care and assuring older adult and caregiver voices are central to care.

1. Establish a narrative that wellbeing and quality of life is both an individual and a community responsibility across the life course.

2. Implement dementia education in healthcare systems and in communities to increase dementia capability.

3. Ensure a geriatric competent workforce.
   a. Collaborate on basic education regarding the cultural shift to integrated, person-centered care.
   b. Ensure curriculum is focused on geriatrics and the value of older adults and caregivers.
Next Steps

The Minnesota Leadership Council on Aging adopted a Strategic Plan in 2016 that included a core strategy of inspiring partnership and action to advance effective integration of care and services for older adults and their caregivers. To that end, the Council established a Task Force to analyze the recommendations from the Summit outlined in this report and to develop a plan to continue conversations and move recommendations forward.

The Council is committed to working with others on this important endeavor. For more information, or to become involved in the work, contact MNLCOA Executive Director Rajean Moone at rajean@mnlcoa.org.

About the Summit

Prior to the 2015 Summit, participants reviewed a concept paper entitled “Making the Case for Integrating Medical and Social Care for Frail Older Adults.” (http://bit.ly/1TDx8rO). The paper outlined the case for working collectively to integrate care across sectors as well as described key elements for successful integration.

Participants at the Summit worked in groups comprised of consumers; caregivers; and at least one leader from each sector of health care, long-term care, and community based services. To get discussions started, each group used a case study with a slightly different but similar scenario: An 82-year-old female with multiple chronic conditions, experiencing moderate dementia. She had a daughter that served as a long distance caregiver. Most recently she visited an emergency room and had an experience that did not go well.