Consumer

value  seniors
effective consumer triple health better
consumers use medical aim
availability supports comprehension systems aligned
safe personalized services
choice opportunities quality flexible
opportunities available daily
affordable communications ease

affordable
care

goals continuum-wide

state

education

care

continuum

health

functions

senior

understood
directed

able
caregiver

listening

metrics

broadened

cooperation

areas

broad

housing

user

employment

metrics
Community Based Providers
Health Care Providers
Long Term Care
Together
Case Studies

- 82, female
- Multiple chronic conditions
- Moderate dementia
- Long distance daughter caregiver
- Emergency room visit – did not go well
A Teams

• Responsive and holistic person and family centered care
• Use best models such as health care home where medical and community based care are connected
• Financing – expand coverage under Medicare & reimbursement model changes
• Delivery systems redesign – social model / determinants of health, culture changes across sectors, cultural competency, care partnerships – families and patients
B Teams

- Person centered culture truly embedded throughout (provider and community wide)
- Care coordinator/navigator with authority and knowledge (medical and social)
- Include, empower and support family caregivers
- Foster notion of individual and community responsibility and capability
- Re-align funding to support integrated & person-centered care models
C Teams

1. Education → consumers and providers
2. Create structure to advance work identified
3. Fund care management and care coordination for all seniors
4. Payment reform – realign Medicare payment to pay for all services including HCBS