

Health and Social Services Linkages for Complex, Frail and/or Disabled Older Adults

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Aging of the US Population

- By 2030: 20% 65 and over, including 75 million baby boomers
25% 60 and over
- Oldest old increasing most rapidly
- Fewer children to be caregivers
- High % of older women living alone
- 20% of older adults isolated, vulnerable

Prevalence of Disease and major Geriatric conditions: persons ≥ 65

Arthritis	48%	Cataracts	17%
<i>Disability</i>	40%	Depression	15%
Hypertension	36%	Cancer	15%
<i>Falls</i>	30%	Diabetes	10%
Hearing Imp	30%	<i>Urinary Incont</i>	9%
Heart Disease	27%	Visual Imp	8%
Influenza	21%	Asthma, Emph	8%
<i>Disabled, IADL</i>		Alzheimers Dis	7%
<i>Or ADL</i>	21%	<i>Frailty</i>	7%

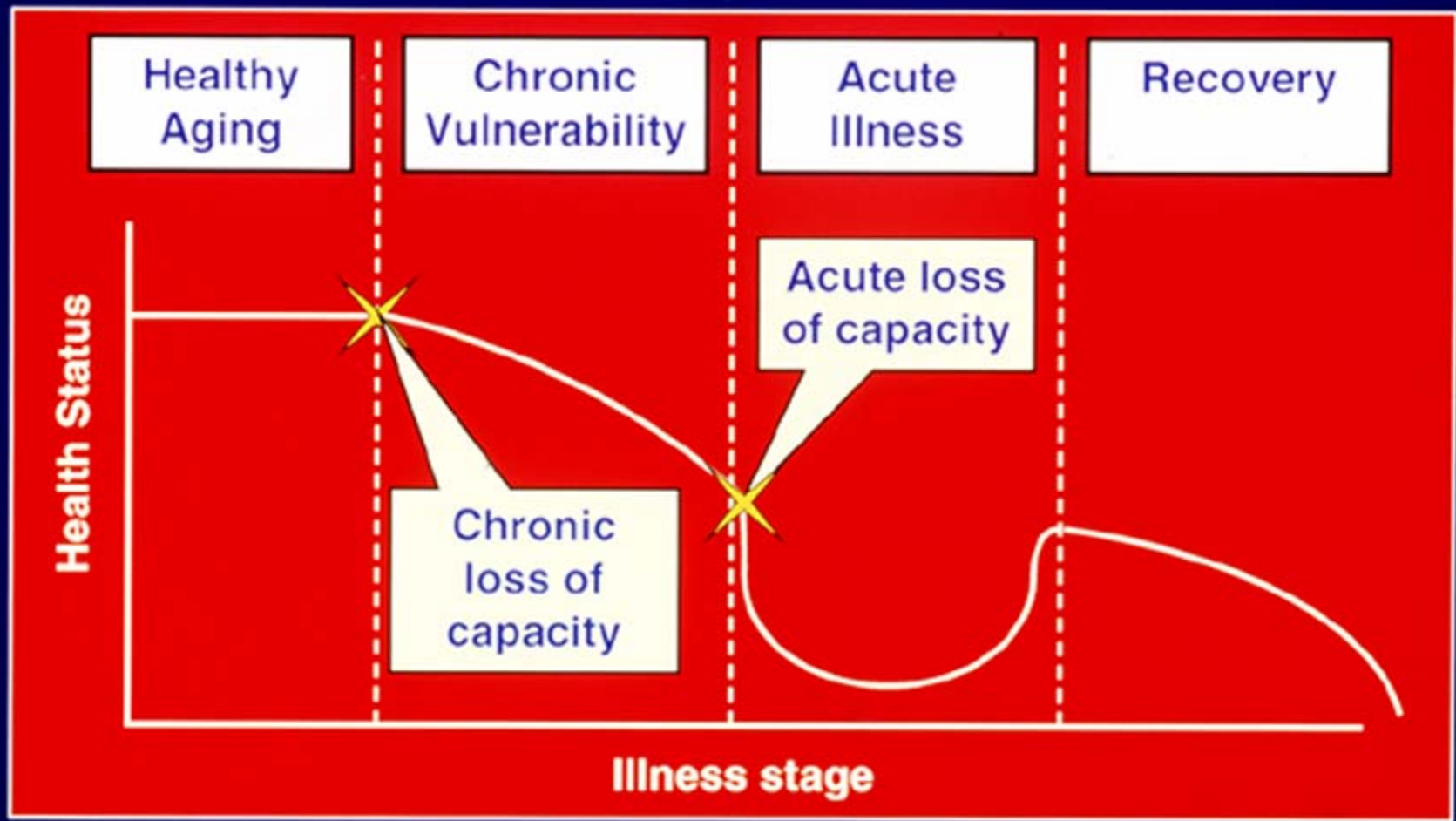
Demographic challenges: health needs and care of older adults differs

- Heterogeneous in health status
 - Chronic diseases: 1: 78%; ≥ 2 : 63%
 - Frail: 7-30%
 - Cognitively impaired: 5-40%
 - Disabled 40%; nursing home 5%
- Health needs and goals change with age
- Acute Care models in a chronic condition world
- Clinical care siloed;
- Frail older adults: vulnerable to illness, hospitals
- Critical for health:
 - Prevention: clinical and community
 - Community services

Heterogeneity of Older Adults. Different Care Needs for Different Health Status



Continuum of Health Status



Challenge I: The Health Care System Not Ready for Aging

- Acute care episodes in a chronic disease world
- Evidence for effective geriatric care not implemented or reimbursed
- One size fits all care for adults vs heterogeneous
- Home-based care often preferable;
- Siloed care leads to discontinuities that adversely affect outcomes; need linkage to community
- Community based continuum of care needed
- Care transitions not managed effectively

Challenge II: The Public Health System Not Ready for Aging

- Responsibility for public and community health for an aging population not allocated
- Evidence on primary, secondary and tertiary prevention for older adults not implemented through public health
- 20% of older adults in community isolated, without access to care; ineffective, undesigned links to clinical care provision
- Is home-based care public health or clinical care?

Challenge III: New institutions needed to promote health in aging

- Civic Engagement
- Redesign of communities
- NORCs;
- Health care at home

Challenge IV: Our Workforce Not Ready for Aging

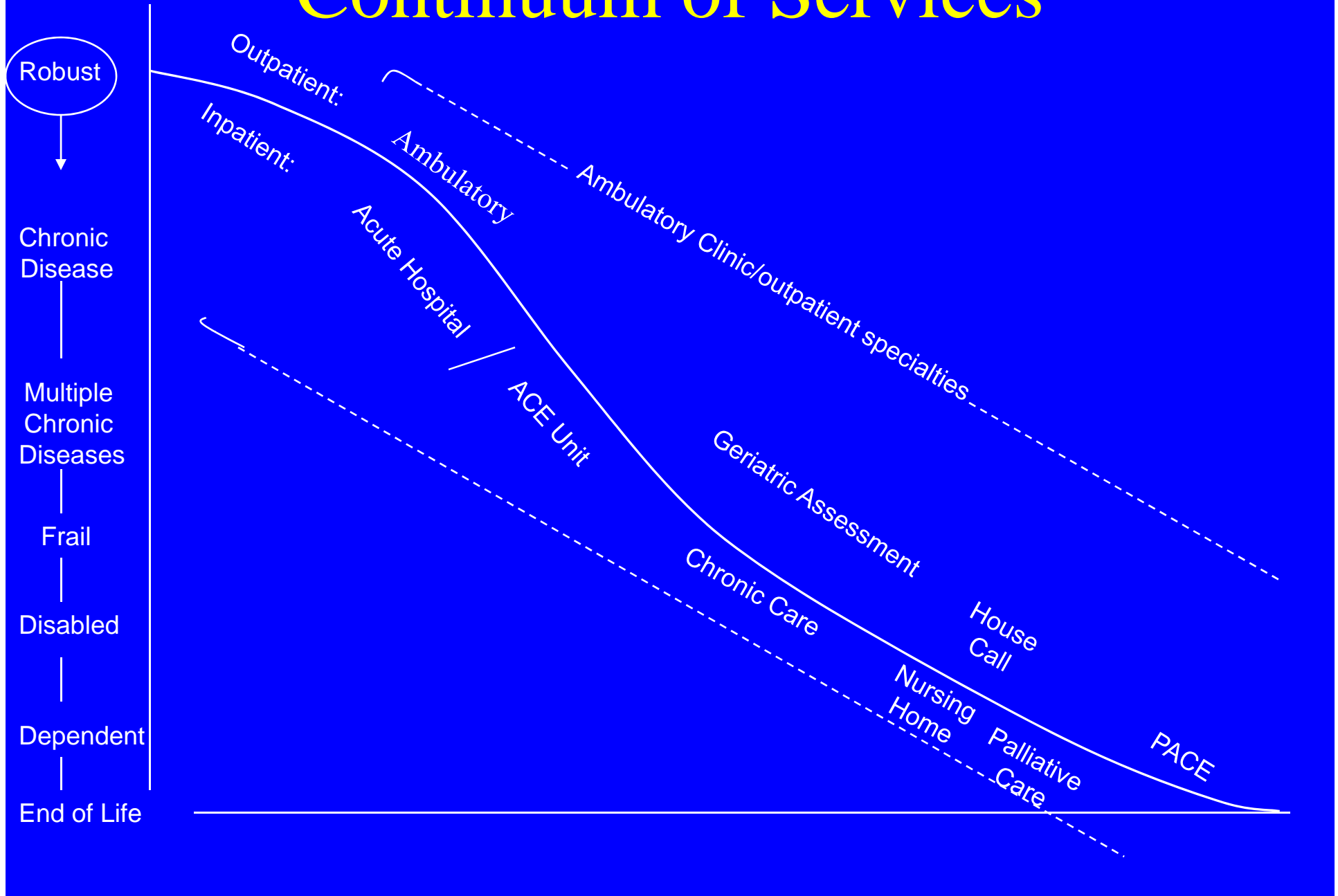
- Creating a geriatrically well-trained workforce:
 - Clinically: All Internists competent in geriatric care
 - Adequate numbers of geriatric physicians, nurses, social workers with special expertise
 - Public Health
 - Community service providers
- Creating enough numbers of geriatrically trained physicians and nurses.

Overarching Solutions: Translation of Evidence into Practice

- Coordinated continuum of health care;
- Systems of care support transitions
- Appropriate provider reimbursement for care of complex older adults
- Responsibility for public and community health assigned and financed
- Integrated with community-based care and service provision
- Regional Electronic Medical Record
- Services carefully designed to facilitate “aging in place”
- Communities redesigned to foster physical activity, engagement, community, safety, access

Tenet of Geriatrics: Systems of Care Matter

Continuum of Services



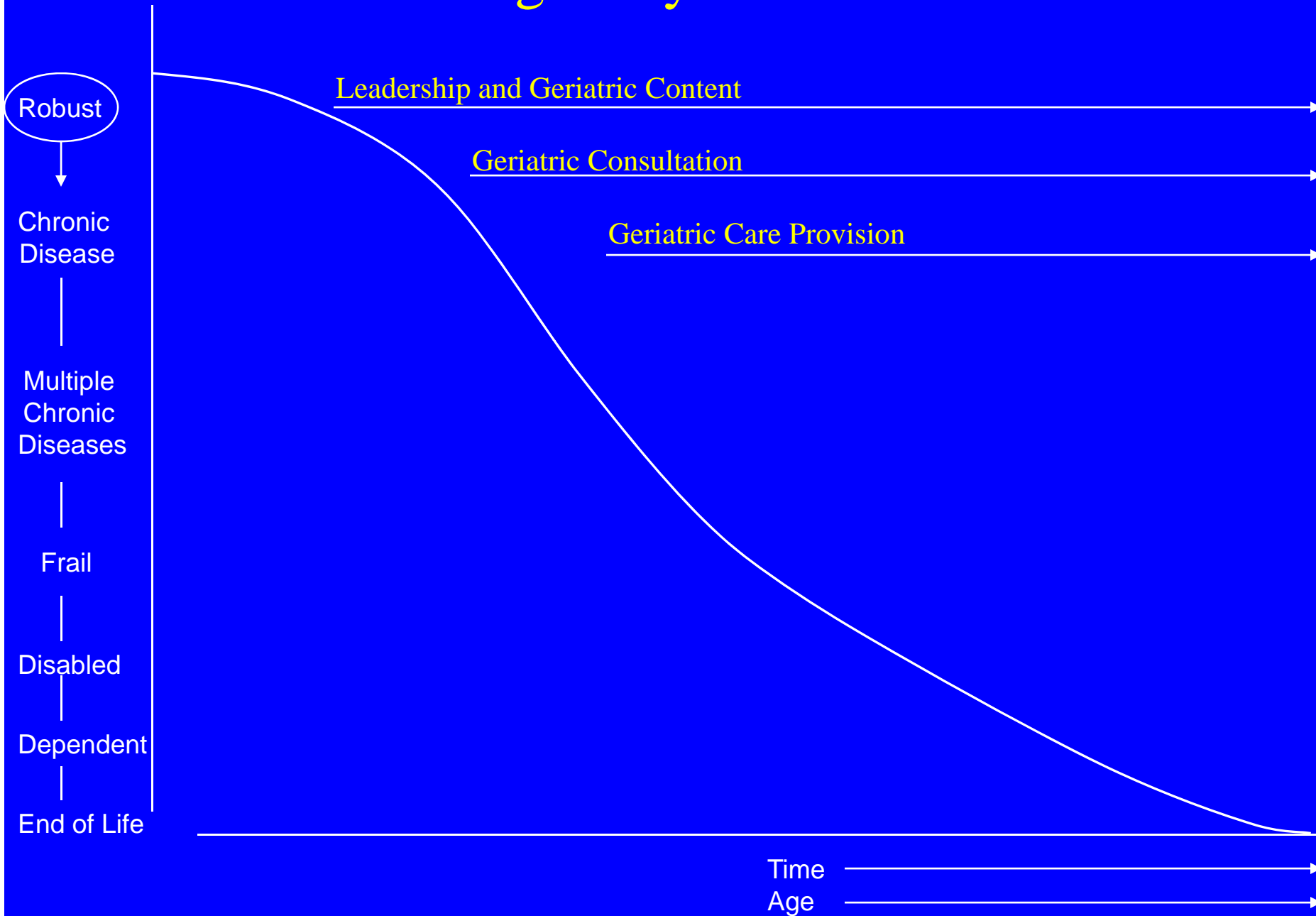
Care Transitions: A major point of vulnerability in health

- Solution: integrated system of care:
 - Regional electronic medical record; geriatrically appropriate
 - Systems of care support transitions
 - Health provider reimbursement for effective care during transitions

Expertise of Geriatric Clinicians

- Content knowledge: heterogeneity; physiology; diseases; geriatric syndromes; prevention; prognosis; risk
- Optimism / realism about aging
- Cognitive skills and strategies: expertise in complex problem analysis; patient-centered
- Practice Models: Interdisciplinary teams
- Systems of Care: targetted to health status, situation

Heterogeneity of Older Adults



Challenge: The Baby Boomers Start Turning 65 in 4.5 years

We only have 1/5 the number of
geriatricians needed now; anticipate much
lower proportion of what will be needed in
2030

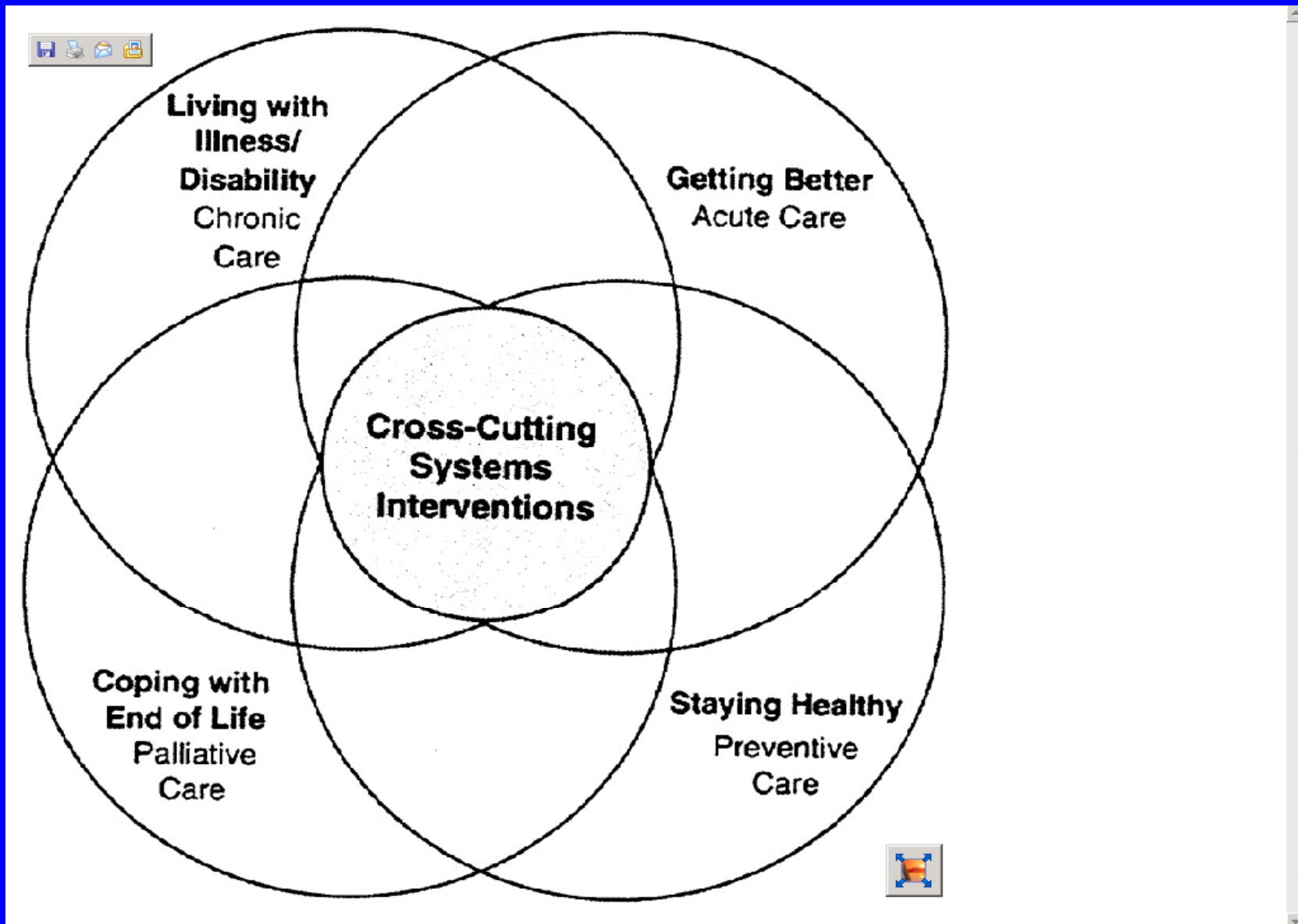
What can be done to insure that there are enough geriatricians for our country's surging elderly population?

- “Nothing; it’s too late”
- Targetting geriatricians to subsets of older adults most likely to benefit
- Training internists and family physicians to be geriatrically: a) Expert; b) Competent
- Expand and fund geriatrics teams, including geriatricians and geriatric Nurse Practitioners

Have to establish new models that
integrate community and public
health for older adults into the public
health system

How can health care for older adults with frailty, disability, multiple chronic conditions be holistic and well coordinated, and integrate with health, community and social service components?

Priority Areas for National Action, IOM 2003



This is the moment for investing in a
wise and strategic transition to a
positive aging society

- 10 years til all Baby Boomers 65
- Time for big picture, vision, innovation, R and D
- Large issues need to be tackled, selected programs optimized if in a changed context
- Requires long-term strategic plan

The Universe of Health Care and Health and Independence Promotion for Older Adults

