
LeadingAge
Continuum
Concierge Services
What if

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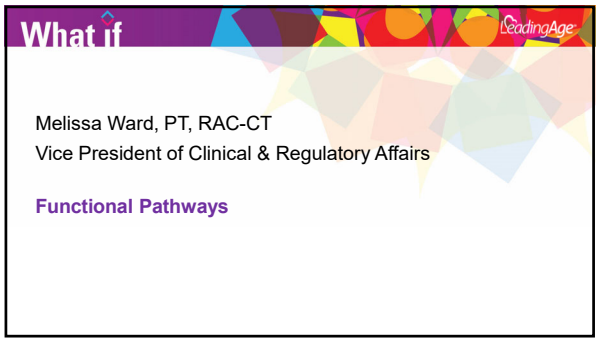
What if
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Melissa Ward, PT, RAC-CT
Vice President of Clinical & Regulatory Affairs
Functional Pathways

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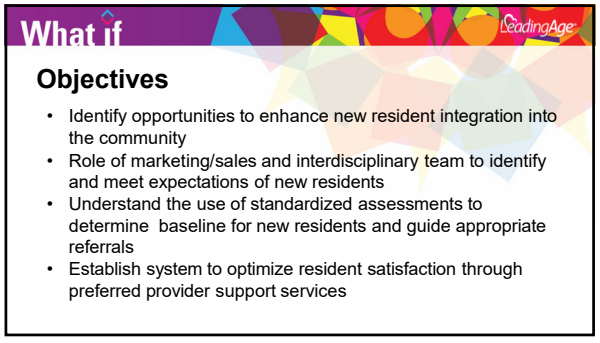
What if
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Objectives
Identify opportunities to enhance new resident integration into the community
Role of marketing/sales and interdisciplinary team to identify and meet expectations of new residents
Understand the use of standardized assessments to determine baseline for new residents and guide appropriate referrals
Establish system to optimize resident satisfaction through preferred provider support services

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Perspective

"If the senior housing industry can bring primary care onsite on a large scale in the next few years, it can become the predominant pre-acute provider of care in the health care continuum"

Andrew Carle, Carle Consulting LLC

February 2019

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What if

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Innovation to Meet the Need

- Health care costs for seniors are soaring, health levels are plateauing, and experts are searching for solutions.
- Senior housing may hold the key
- In 2019, senior living can become the power player of the care continuum by delivering primary care directly to its residents.

Source: Research Report Senior Housing News

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Innovation to Meet the Need

- Research has demonstrated improved health outcomes for seniors when time with primary care physicians increases
- Provide continuity of care within the community
- Right services at the right time to maintain viability of residents remaining in their home environment

Source: Research Report Senior Housing News

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What if

Transition

- (noun) movement, passage, or change from one position, state, stage, subject, concept, etc., to another
- (verb) to make a transition, change

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What if

Remember

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What if

Continuum Concierge Program

Innovative strategy to promote successful transition into a retirement community

- Sales/marketing
- Reduce risk of residents leaving the community
- Resource for family members

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Continuum Concierge Program

The goal of the program is to enhance a resident's experience through a comprehensive interdisciplinary approach

- Empower residents to thrive in the new community
- Identify of medical and non-medical aspects of care
- Support those aging in place

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Continuum Concierge Program

Full collaboration may include physicians, physician extenders, social services, nursing, therapy, activities and wellness.

The program can be easily modified for implementation across the community's continuum of care.

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Philosophy

Independent Living

versus

Continuum of Care

- Unique opportunity to provide a resident focused program to set your community above others. Family members can become an active part of this process.
- Empowerment – the individual feels they have the ability and opportunity to make choices and have input in their own life.

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Introspection

- New resident orientation
- Resident-driven support group
- Identification of residents at risk
- Physician services
- Preferred provider networks
- Collaborative between continuum of care

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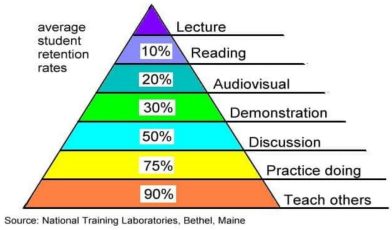
Learning Pyramid



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Operational Components

- Role of Resident Services coordinator for IL and AL
- Determine departments who will be involved
  - Physician
  - Social services
  - Nursing
  - Therapy
  - Activities
  - Wellness
- Upon referral, a comprehensive screen will be completed to determine if support services are indicated

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Operational Components

Skilled Part B services versus private pay

- Frequency
  - Skilled Part B services duration will be based on the care plan
  - The average number of visits will be 5-10 sessions for private pay
- Coordination of care through social services
- Option to integrate into AL annual care plan review

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Continuum Concierge Program

- Standardized assessments are used to determine current status and areas for potential risk
- Results guide the foundation for client- based services needed for full integration into the daily activities of the community

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Comprehensive Assessment

- Gait speed
- Balance
- Lower extremity strength
- Cardiopulmonary status
- Cognition
- Low vision
- Instrumental activities of daily living
- Depression

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Prevalence of Cognitive Impairment

- A study published in 2014 in *Health Affairs* found that 70% of assisted living residents have some form of dementia, whereas according to the Centers for Disease Control and Prevention, more than 50% of nursing home residents are affected by it.
- In the community, 15-20% have mild cognitive impairment
- In the community, approximately 11% of older adults have dementia.

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Prevalence of Cognitive Impairment

- 61% of older adults with MCI were dependent in at least one IADL.
- Compared to individuals with normal cognition, people with MCI had greater odds of being dependent on 7 of the 10 specific IADLs.
- BCAT® factor scores can be used to identify IADL risk, especially for managing finances, meal preparation and remembering events (including medications).

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Prevalence of Cognitive Impairment

These dynamics require *all* long-term and post-acute care providers to consider the following:

- The line between "memory care" as a separate and distinct service in assisted living communities and nursing homes soon will be blurred and eventually will disappear as it becomes more and more obvious that dementia care should be an integral component of all training and education for anyone who works in the field of aging services.
- To properly educate and train staff (as well as families) to ensure the provision of high-quality care for PLWD, providers in all settings and categories must acknowledge the damaging stigma that is attached to dementia. Real emotional and social implications are affiliated with having cognitive impairment. Therefore, providers must begin with an examination of our own fears and misperceptions about dementia and reflect on how these affect PLWD.
- Most traditional models of dementia care focus on residents' inabilities and losses and on mitigating problem "behaviors." More progressive and innovative approaches, on the other hand, explore the often-unrecognized biases that shape interactions with PLWD and help direct care staff learn a whole new way to engage with each elder by focusing on the building blocks of culture, meaningful engagements and health and well-being.

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What if

Prevalence of Cognitive Impairment

- Sub-optimal management of medical conditions
- Inflated rate of hospital readmissions
- Increased frequency of falls
- Lowered rehabilitation services outcomes
- Sub-optimal discharge planning
- Increased risk for losing independence

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Standardized Assessments

Community Member: _____ Date: _____

Clinician: _____

Assessment	Resident Score	Interpretation
Timed Up and Go Test (Gait Speed)	Score = _____ Score takes ≥12 seconds indicate high fall risk	□ Skilled therapy indicated □ No skilled therapy indicated
30 Second Sit to Stand Test (LE Strength)	Score = _____ Age / Men / Women 60-64 / <14 / <12 65-69 / <12 / <11 70-74 / <12 / <10 75-79 / <11 / <10 80-84 / <10 / <9 85-89 / <8 / <8 90-94 / <7 / <4 A score below norm for age and gender indicates high fall risk.	□ Skilled therapy indicated □ No skilled therapy indicated
4 Stage Balance Test (Balance)	Score = _____ An older adult who cannot hold the tandem stance for at least 10 seconds indicates high fall risk	□ Skilled therapy indicated □ No skilled therapy indicated
2 Minute Walk Test (Cardio-pulmonary)	Score = _____ Observation of gait and cardiopulmonary response. Used as baseline, not compared to norms.	□ Skilled therapy indicated □ No skilled therapy indicated

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Standardized Assessments

Community Member: _____ Date: _____

Clinician: _____

Assessment	Resident Score	Interpretation
SLUMS (Cognition)	Score = _____ High School Education / / Less than High School education 27-30 / Normal / 20-30 20-27 / MCI / 14-19 1-19 / Dementia / 1-14	□ Skilled therapy indicated □ No skilled therapy indicated
Smith Low Vision Assessment	Score = _____ Based on resident self-report of visual challenges with daily activities	□ Skilled therapy indicated □ No skilled therapy indicated
Lawton Instrumental Activities of Daily Living Scale	Score = Based on resident self-report of 8 items that are rated with a summary score from 0 (low functioning) to 8 (high functioning)	□ Skilled therapy indicated □ No skilled therapy indicated
Geriatric Depression Scale Short Form	Score = A score > 5 points is suggestive of depression. A score ≥ 10 points is almost always indicative of depression. A score > 5 points should warrant a follow-up comprehensive assessment	□ Referral for services □ No referral for services

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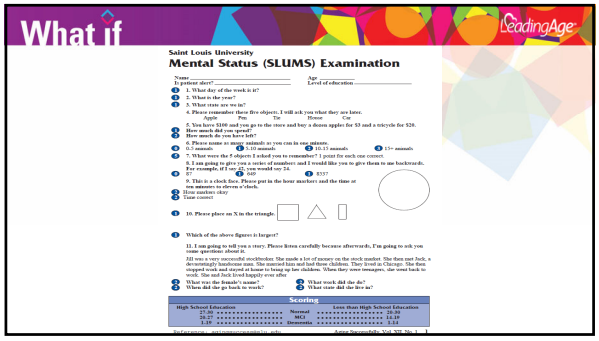
What if
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Saint Louis University
Mental Status (SLUMS) Examination

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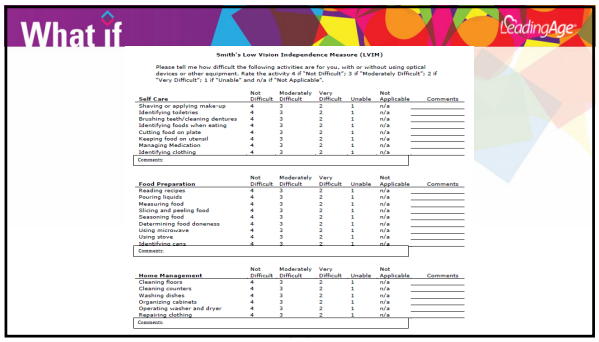
What if
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Smith's Low Vision Independence Measure (LVIM)

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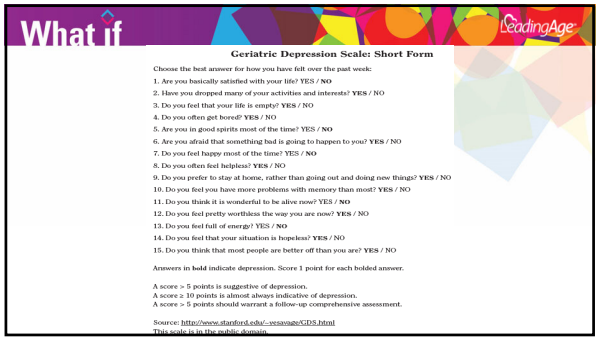
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Geriatric Depression Scale: Short Form

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Functional Mobility and Fall Prevention

- Completion of standardized assessments
  - Time Get Up and Go Test
  - Sit to Stand Test
  - 6 Minute Walk Test
- Mobility in home environment and community locations (dining room, bistro and mailbox)
- Stair navigation
- Completion of standardized assessments
  - Time Get Up and Go Test
  - Sit to Stand Test
  - 6 Minute Walk Test
- Mobility in home environment and community locations (dining room, bistro and mailbox)
- Transfers
- Durable medical equipment use

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What if

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Home Safety

- Wearing/use of emergency pendant and alarms
- Windows and doors
- Appliances in kitchen and bath
- Access to items in cabinets
- Lighting/ventilation
- Electrical controls (lights/outlets/alarms)

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What if

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Low Vision

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What if

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Basic and Instrumental Activities of Daily Living

- Location of home; manipulation of doors, knobs, locks of home and facility
- Location of community resources: mail, bathrooms
- Energy conservation, work simplification
- Manage pet food and care
- Laundry
- Dishwashing
- Low vision modification
- Organization of living space
- Manage trash and recycling
- Organize and manage mail and bills

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What if

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Medical Management

- Obtain and organize medications
- Vital signs, weight monitoring
- Physician and medical appointments
- Transportation
- Community based services
- Nutrition

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Community Integration

- Transportation system
- Social activities
- Wellness schedule
- Knows neighbors
- Shopping resources

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Scoring the Checklist

- Pass = Therapy team member has observed resident completing the task without difficulty
- No-Go = Therapy team member has observed resident unable to complete the task or does so in an unsafe or inconsistent manner
- Intervention = Feedback from the therapy team member on environment modifications, resources and/or need for skilled services

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Enhancement Opportunities

- Pre-sales
- Collaborative team with resident and family
- On-site medical support
- Private pay needs assessment
- Optimize successful transition for new residents and those aging in place
- Coordination between post acute providers

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Summary

- Transitional program is designed for successful integration into a life care community as well as helping residents remain in their current level of care for as long as possible.
- Therapy will provide professional assessment of the resident's ability to complete the items on the checklist
- Recommendations will be made to the community liaison.

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