RNCM Role in Long Term Services & Supports

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- Long Term Services & Supports
- Activities of Daily Living
- Instrumental Activities of Daily Living
- Caregiver Burden
- LTSS Eligibility
- HCBS – Home & Community-Based Services
- Frailty
- LTSS State Scorecard
- Nursing Homes, Residential Home
- Assisted Living Facility
- Adult Day Health Care
- Home Health Aide
- Homemaker Services
- PACE
- CAPABLE
- Hospital At Home
- Veteran Directed Care

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Long Term Services & Supports

An Overview

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Defining Long Term Services & Supports

Broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition.

– Congressional Research Service, 2021

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"Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and complex care tasks provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health conditions that is expected to continue for an extended period of time, typically 90 days or more."

– AARP Public Policy Institute

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LTSS provides assistance in maintaining or improving an optimal level of physical functioning and quality of life

- Differs from acute care or post-acute care services
- LTSS is not intended to treat or cure a medical condition
- LTSS may be offered in combination with acute or post-acute care services

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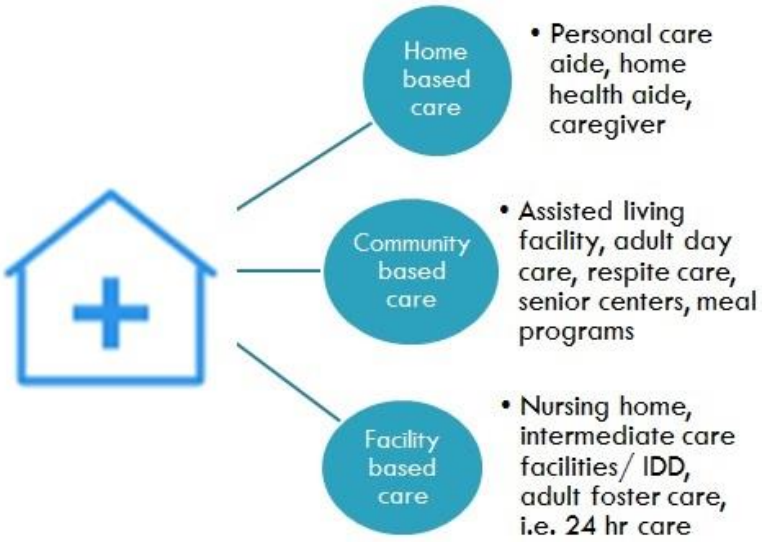

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Who Needs LTSS?

- Children born with disabling conditions
- Working-age adults with inherited or acquired disabling conditions
- Elderly with chronic conditions or diseases

LTSS is measured by:

- the presence of functional limitations specifically ADLs and IADLs
- the need for supervision or guidance with ADLs due to mental or cognitive impairment

NATIONAL Registered Nurse Practice Development Center
National Registered Nurse Case Manager Certificate Program

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Measures for LTSS Needs

Activities of Daily Living (ADLs)

- Eating
- Bathing
- Using the toilet
- Dressing
- Walking across a small room
- Transferring – getting in and out of a bed or chair

*Katz Index of Independence in ADLs

Instrumental Activities of Daily Living (IADLs)

- Preparing Meals
- Managing Money
- Shopping
- Performing Housework
- Using a Telephone
- Doing Laundry
- Getting around outside the home
- Taking Medications

*Lawton Instrumental ADLs

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Probability of Needing LTSS Increases with Age

56% who survive to age 65 will develop a disability serious enough to need LTSS

10% will need care for less than a year

22% will need care for five or more years

As the population ages the demand for LTSS is expected to increase

Advances in medical and supportive care are enabling younger persons with disabilities to live longer lives requiring LTSS for longer time

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Caregiver Burden

- Personal Care
  - Bathing
  - Dressing
  - Toileting
- Complex Care
  - Medications
  - Wound care
- Help with Housekeeping, Transportation, Paying Bills, Meals
- Social Services

Most in home care is provided by unpaid, family caregivers

LTSS Eligibility

Based on number of limitations in specific ADLs

- Public Payors
  - State Medicaid Programs
  - Have flexibility in determining LTSS need
  - "Level of Care"
- Private Payors
  - Long-term care insurance policy required to have defined benefit triggers for when a policy begins to pay LTC benefits
  - Requires policyholders to be certified by a licensed health care provider as unable to perform at least 2 ADLs for a minimum of 90 days or require substantial supervision due to severe cognitive impairment

Who Provides Paid LTSS?

65,600 paid, regulated LTSS providers served > 8.3 million individuals

-The National Center for Health Statistics, 2016

- 28,900 residential care homes & communities
- 15,600 nursing homes
- 12,200 home health agencies
- 4,600 adult day health centers

(All but Adult Day Health Centers were for-profit)

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- Licensed/Skilled Healthcare Workers
  - RNs, LPNs, Physical & Occupational Therapists, SW
- Non-licensed providers
  - direct care workers: home health aides, personal care aides, nursing assistants
  - 4.6 million direct care workers
    - 2.4 million worked in home care
    - 730,000 residential care homes
    - 570,000 nursing homes
    - 900,000 other industries

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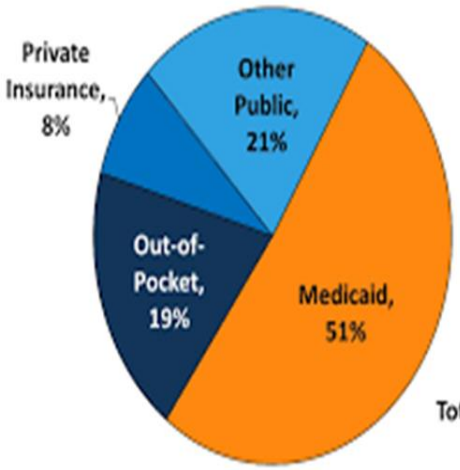
The Cost of LTSS

LTSS costs varies widely:

- Individual's underlying conditions
- Severity of disability
- Setting in which services are provided
- Caregiving arrangement (Paid vs uncompensated care)



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Median Rate for LTSS Providers, 2020

	Daily Rate	Monthly Rate	Annual Rate
Nursing Home (Private) – Provides higher level of care in a residential setting with 24-hour skilled nursing supervision	$290	$8,821	$105,850
Home Health Aide – Provides assistance with personal care & other routine activities in a person's home	$150	$4,576	$54,912
Homemaker Services – Provides routine activities in a person's home (meals, laundry, housework, etc.)	$147	$4,481	$53,768
Assisted Living Facility – Provides personal care and limited health services in a residential setting; the level of care is not as extensive as a nursing home	$141	$4,300	$51,600
Adult Day Health Care du– Provides social & supportive services in a community-based setting, usually during workday hours	$74	$1,603	$19,240

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Family Caregiver Costs

- Caregivers spent an average of $7000+ on caregiving costs
- Long distance caregivers average $12,000+
- 1:5 caregivers experience high level of financial strain
- 20% experienced reduced income

Needed: A High Performing LTSS System

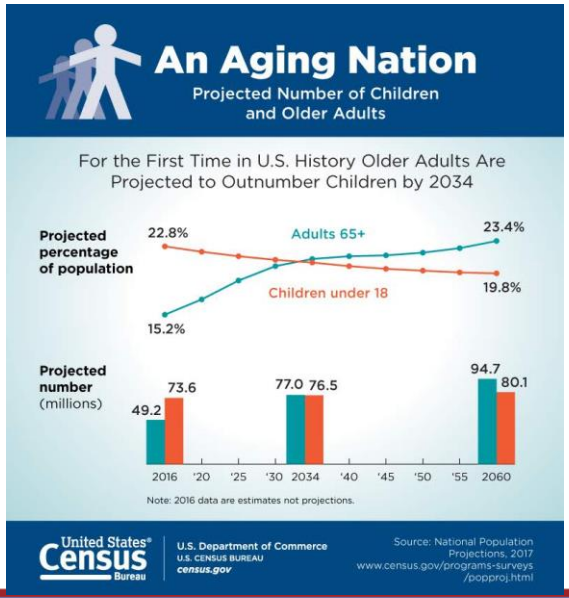
Driven By A Growing & Shifting Population

LTSS & Aging Population

Over Age 65

- 2010 – 40 million
- 2019 – 55 million
- 2035 adults over age 65 > children under age 18

Strong LTSS Needed to Meet the Needs of an Aging Population



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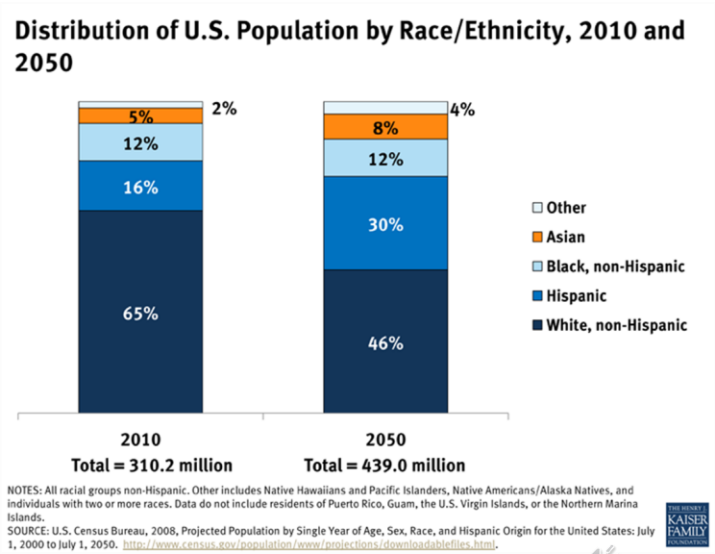
LTSS & A More Diverse Population

- Non-Hispanic white older adults has decreased
- Black, Hispanic, Native & Asian Populations grew faster



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LTSS, Frailty & Function

- Frailty is a clinical syndrome in older adults that carries an increased risk for poor health outcomes including falls, incident disability, hospitalization, and mortality
- 3 of 5 Factors:
  - Unintentional weight loss
  - Low physical activity
  - Muscle weakness
  - Slowed performance
  - Fatigue or poor endurance

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Frail Questionnaire

Component	Question
Fatigue	How much time during the previous 4 weeks did you feel tired? (All the time, Most of the time = 1 point)
Resistance	Do you have any difficulty walking up 10 steps alone without resting and without aids? (Yes = 1 point)
Ambulation	Do you have any difficulty walking several hundred yards (1 block) alone without aids? (Yes = 1 point)
Illness	How many illnesses do you have out of a list of 11 total? (5 or more = 1 point) (Hypertension, Diabetes, Cancer, Chronic Lung Disease, Heart Attack, Angina, CHF, Stroke, Asthma, Arthritis, Kidney Disease)
Loss of Weight	Have you had weight loss of 5% or more in the past 6 months? (Yes = 1 point)

Frail score ranges from 0-5, one point for each component, 0=Best 5= worst

Robust = 0 points, Pre-frail = 1-2 points, Frail = 3-5 points

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Demand for Home & Community-Based Services to Grow

90% of adults needing LTSS reside in the community

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High Performing LTSS System

- *LTSS State Scorecard*
- 5 Dimensions

AARP Public Policy Institute

EXHIBIT 1 Framework for Assessing LTSS System Performance

HIGH-PERFORMING LTSS SYSTEM

Five dimensions of LTSS performance, constructed from 26 individual indicators.

AFFORDABILITY AND ACCESS	CHOICE OF SETTING AND PROVIDER	QUALITY OF LIFE AND QUALITY OF CARE	SUPPORT FOR FAMILY CAREGIVERS*	EFFECTIVE TRANSITIONS
1. Nursing Home Cost	1. Medicaid LTSS Balance: Spending	1. PWD Rate of Employment	1. Supporting Working Family Caregivers	1. Nursing Home Residents with Low Care Needs
2. Home Care Cost	2. Medicaid LTSS Balance: Users	2. Nursing Home Residents with Pressure Sores	2. Person- and Family-Centered Care	2. Home Health Hospital Admissions
3. Long-Term Care Insurance	3. Self-Direction	3. Nursing Home Antipsychotic Use	3. Nurse Delegation and Scope of Practice	3. Nursing Home Hospital Admissions
4. Low-Income PWD with Medicaid	4. Home Health Aide Supply	4. HCBS Quality Benchmarking	4. Transportation Policies	4. Burdensome Transitions
5. PWD with Medicaid LTSS	5. Assisted Living Supply			5. Successful Discharge to Community
6. ADRC/NWD Functions	6. Adult Day Services Supply			
	7. Subsidized Housing Opportunities			

ADRC/NWD - Aging and Disability Resource Center/No Wrong Door
HCBS - Home- and Community-Based Services
LTSS - Long-Term Services and Supports
PWD - People with Disabilities
*Support for Family Caregivers Dimension evaluated across 12 individual policies, which are grouped into four broad categories.

Source: Long-Term Services and Supports State Scorecard, 2020.

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In a High Performing LTSS System

- Affordability & Access
  - Consumers can easily find and afford services
- Choice of Setting & Provider
- Quality & Safety
- Support for Family Caregivers
- Community & Integration

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Challenges to LTSS

- Financing of LTSS
  - Waivers
  - Expanding PACE
  - Innovative Payment Models
- Addressing Disparities
  - Equitable distribution of HCBS
  - Screening for social needs/coordinating resources
- Workforce Development
  - Well-prepared workforce at all levels
  - Increased assistance from technology & assistive devices

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Nursing Homes & Residential LTSS Settings

- COVID-19 exposed long standing structural problems
  - Inconsistent staffing
  - Lack of sufficient oversight
  - Low paid workforce
  - Risk of congregate settings

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"The way in which the United States delivers and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable."

-The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families & Staff. NASEM, 2022

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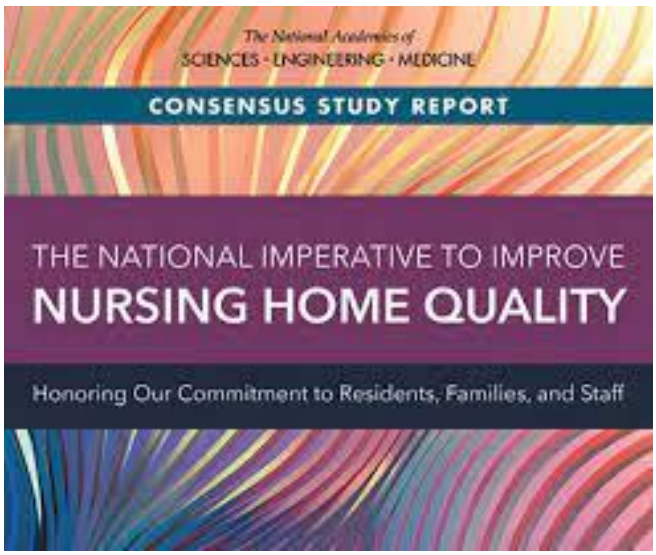
Nursing Home Challenges

- Decline in nursing home occupancy
- No minimum staffing ratio
- Inadequate staffing - Registered Nurses = better outcomes
- Worsened disparities & segregation for Black & Hispanic residents



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RNCMs & LTSS

Implications & Emerging Practice Models

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Implications for RNCM Practice

Including LTSS Providers in Transitions of Care:

- LTSS providers a critical link to safe home & community care transitions however not routinely included on the patient care team
- LTSS providers often not informed when someone in their care is sent to ED or admitted to the hospital
- Connecting with LTSS providers during care transitions is left for the family caregiver
- LTSS providers frequently lack technology/EHR interface making them more vulnerable to exclusion

Anticipate and embrace interaction with LTSS providers to facilitate a safe, efficient care transitions

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Communicating with LTSS Providers

- Ask specific questions regarding services and supports that the patient is receiving at home or in the community
- Take time to actively engage LTSS providers by speaking with them directly to learn more about the individual and their services
- Help LTSS providers recognize at risk clients who are more likely to transition to an inpatient setting. Design a plan to communicate this change in status.
- Determine the credentials of the LTSS staff you are working with – if transition conversations require a clinician-to-clinician conversation, it is important to know who you are talking with

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LTSS Care Model

Program for All-Inclusive Care for the Elderly (PACE)

Typical PACE participant is similar to the average nursing home resident. The typical participant is an 80-year-old woman with eight medical conditions and limitations in three activities of daily living. Nearly half (49%) of PACE participants have been diagnosed with dementia. Despite a high level of care needs, more than 90% of PACE participants are able to continue to live in their community.

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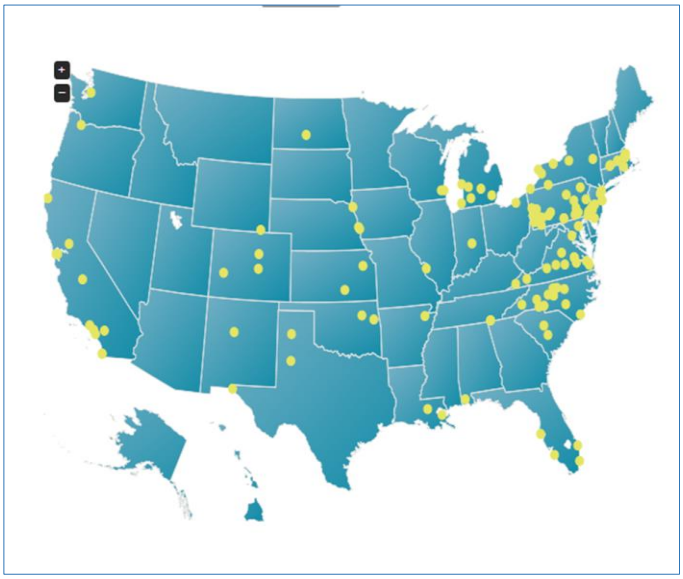
148 PACE Programs
273 PACE Centers
32 States

Eligibility:

- Must be age 55 or over
- Live in a PACE service area
- Be certified by the State to need nursing home level care

Find a PACE Program

- https://www.npaonline.org/pace-you/pacefinder-find-pace-program-your-neighborhood



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Implications for RNCM Practice:

- Establish relationship with PACE Team
  - Referrals and follow up
- RNCM may be active team member
  - Population Health Management
  - Assessments
  - Care Coordination of Care Services
  - Home Visiting
  - Remote Home Monitoring
  - Virtual Clinic Visits

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LTSS Care Model

Community Aging in Place – Advancing Better Care for Elders (CAPABLE)

- Participant driven home care
- 34 CAPABLE sites
  - 9 rural
- Candidates
  - Persons with chronic conditions recently discharged from the hospital with functional limitations
  - Low-income older adults, Medicare/Medicaid

- CAPABLE Team:
  - Registered Nurse
  - Occupational Therapist
  - Handy worker
- 10 sessions over 4-5 months
- Goals:
  - To improve function by addressing home environment
  - Use the strengths of the older adult to improve health

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CAPABLE Outcomes:

- 79% of participants improved their self-care over the 5 months
- On average the number of self-care tasks that participants had difficulty were halved
- Participants experienced a decrease in depressive symptoms similar to that of anti-depressant medication
- Lowered healthcare costs: $3000 in program costs/participant = $30,000 in savings in medical costs
- Improved self-efficacy and confidence

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CAPABLE

Implications for RNCM Practice:

- May be integrated into a Care Management Program
- RN provides four 1-hour visits including home visiting
- Uses Motivational Interviewing, Active Listening & Coaching to identify and prioritize patient goals
- Promotes self-efficacy of ADLs and IDALs
- Future: CAPABLE for caregivers

More information Johns Hopkins School of Nursing:

- https://nursing.jhu.edu/faculty_research/research/projects/capable/

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LTSS Care Model
Hospital at Home

- CMS – Acute Hospital At Home Program
  - Provides hospitals with expanded flexibility to care for patients in their homes
- Participating hospitals admit patients from the ED and inpatient beds to their homes
  - Hospitals must apply for a waiver and adhere to screening & safety protocols
- Patients are evaluated by a RN daily and receive two in-person visits daily by either nurses or mobile integrated health paramedics

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Hospital at Home Outcomes:

- Improved health outcomes
- Enhanced patient experience
- Reduced costs

Implications for RNCM Practice:

- Transitional Care Management

More information:

- Johns Hopkins Implementation Approach
  - https://www.johnshopkinssolutions.com/solution/hospital-at-home/
- AHA resources including summary of CMS flexibilities for this program
  - https://www.aha.org/hospitalathome

LTSS Care Model
Veteran Directed Care LTSS

- By 2026 VA Office of Geriatrics & Extended Care expanding to all VAMCs:
  - Home-based Primary Care
  - Medical Foster Home
  - Veteran Directed Care Program
- Goals:
  - Allow Veterans to age in place
  - Delay nursing home placements
  - Choose the care environments that aligns best with veteran care needs, preferences & goals

VDC Outcomes:

- High veteran satisfaction with care
- Improved costs
- Increased access to care hours
- 37% decrease in nursing home placement 1 year after enrollment

Implications for RNCM Practice:

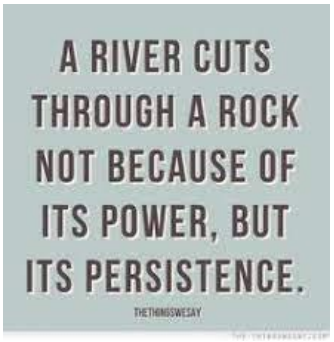
- VA & Private Sector RNCMs can expect to interface with VDC services
- Care Coordination is Key!

More information:
https://nwd.acl.gov/vdc.html

70% of adults who survive to age 65 develop severe LTSS needs before they die

Next Steps

- Watch Posted Videos
- Review Resources
- Complete Practice Development Activity
- Take the Test Your Knowledge Quiz



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