Title

The Right Person at the Right Time: Ensuring Person-Centered Care

Journal

GENERATIONS-JOURNAL OF THE AMERICAN SOCIETY ON AGING, 40(1)

ISSN

0738-7806

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Publication Date

2016

Peer reviewed

The Right Person at the Right Time: Ensuring Person-Centered Care

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Scope of practice and other systems-level factors weigh into providing high value and high-quality care for older adults.

The Institute of Medicine's report, *Retooling for an Aging America*, envisioned care that is responsive to an aging society, with an adequate supply of competent workers and improved delivery systems, including healthcare teams that work together (IOM, 2008). Steven Dawson and Christopher Langston opened this issue of *Generations* with a critical reflection on the incremental and inadequate progress made in meeting the growing demand for eldercare (see page 6) They call for "systems that are designed *from the very beginning* around the core, central relationship between the elder *and* the caregiver."

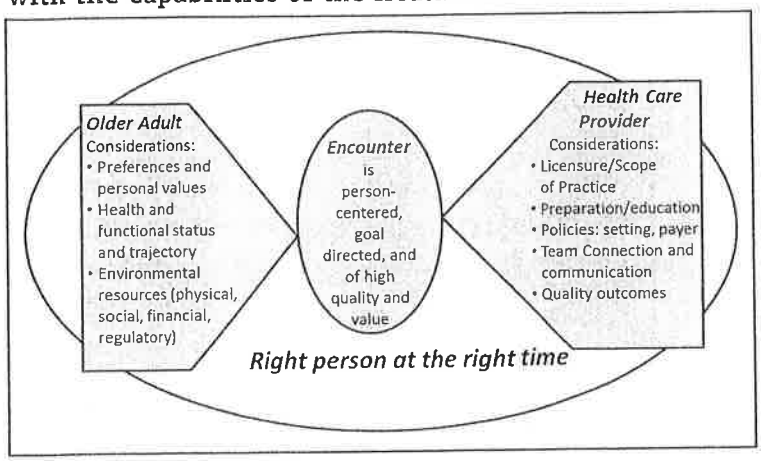
The triple aim of healthcare improves the care experience, advances population health, and reduces per capita cost for care (Berwick, Nolan, and Whittington, 2008). We conceptualize every healthcare encounter as being person-centered (i.e., responsive to the needs, preferences, and goals of the person seeking care) and adding quality and value (see Figure 1, page 48). Healthcare encounters, in this article, mean any time an older adult engages with the healthcare system, whether in a hospitalization involving a large and complex healthcare team, or in a home visit by a community health worker from a clinic-based primary care team.

Older adults and their families want compassionate, respectful, high-quality care—and expect clear and appropriate communication.

Encounters between older adults and healthcare providers are dynamic, change over time, and must reflect, in the most cost-effective way, a match between what older adults and their families value and need, and healthcare providers' (professional and direct care workers) capabilities. Each encounter involves considerations on the part of the older adult

→**ABSTRACT** The diversity of needs and goals among older adults is increasing with demographic shifts. The ability of any healthcare provider to deliver a high-quality/high-value, person-centered encounter depends on a number of factors, including licensure/scope of practice and other systems-level factors, including education/preparation, relevant policies, team connectedness, and quality measures. This article examines the question of scope of practice from a broad perspective of what is needed and what is possible, with the goal of identifying the right person at the right time to provide high-value, high-quality, person-centered care for older adults. | **key words:** *person-centered care, healthcare team, scope of practice*

Figure 1: Matched Goals/Needs of the Older Adult with the Capabilities of the Healthcare Provider



and the healthcare provider(s) that respond to and bring the greatest value. This article examines the question of scope of practice from a broad perspective of what is needed and what is possible, with the goal of identifying the right person at the right time to provide high-value, high-quality, person-centered care for older adults.

Parsing Optimal Healthcare for Older Adults

The diversity of healthcare needs and goals among older adults is increasing with demographic shifts. There can be up to three generations older than age 65, each reflecting the full spectrum of capacity. At one end of the continuum, active, independent older adults may have two chronic conditions requiring adjustments in diet, activity, and medication management. At the other end, older adults with profound functional or cognitive challenges require constant supervision, support, and care.

As older adults experience their health, it is not compartmentalized by specialty or setting, nor organized by body system or payer. At the core, older adults and their families want compassionate, respectful, high-quality care, and expect clear and appropriate communication as they navigate the system and their health—including the physical, psychosocial, functional, and spiritual aspects. Person- and family-centered care emphasizes the older adult's social context and highlights the complexity and diversity of preferences regarding decision making and perspectives of treatment burden (Wolff and Boyd, 2015). Achieving quality and value in healthcare necessitates aligning older adult's personal values and preferences with what the health system is able to provide (Sikma and Young, 2001).

With older adults at the center of care, the delivery system should flex to provide the optimal mix of providers. Yet various systems-level barriers challenge the extent to which older adults receive person-centered care, with environmental context playing a large role. For example, while many older adults prefer aging in place, family and friends' availability to assist with activities of daily living, as well as financial resources (i.e., private funds or medical-financial eligibility for Medicaid services) can determine living situations and drive options for long-term care.

What Can Healthcare Providers Deliver?

Responding to age-associated comorbidities and functionality requires expertise from an ever-expanding professional team that can address disease processes and symptoms, as well as implications for function and quality of life. The field of geriatrics can play an integrative role, honoring the older adult's preferences and choices related to quality of life and their involvement in healthcare decisions, while addressing the complexities of care needs. Yet the majority of older adults, especially in rural communities, do not have access to even one team member with geriatric expertise, let alone an entire team. Any healthcare provider's ability to deliver a high-quality and high-value person-

centered encounter depends upon a number of factors, including their licensure and scope of practice and other systems-level factors such as education and preparation, relevant policies, team connectedness, and quality measures.

Licensure and Scope of Practice

Health professions are regulated and licensed by states to protect the public and uphold standards established by self-regulating professions. Because of state differences, change requires state-by-state strategies. In clinical care, the scopes of practice among health professionals overlap. In highly effective teams delivering care to older adults, there is synergy among the providers and the ability to cover functions efficiently. Scope-of-practice issues are evolving in primary care to include nurse practitioners and physician assistants and, in long-term care, to expand the nursing care delivered by direct care and community health workers.

Primary care

With the looming crisis in the dearth of primary care physicians, removing barriers to full practice by nurse practitioners has gained national momentum. A large body of evidence supports the safety and quality of nurse practitioners providing primary care (Naylor and Kurtzman, 2010; Cassidy, 2012). Since the IOM *Future of Nursing* report (IOM, 2010), the Center to Champion Nursing in America (CCNA) and other professional nursing organizations have been joined by the National Governors' Association (2012) and the Federal Trade Commission (2014) to make the business case for removing barriers to full practice relative to nurse practitioners. Despite opposition to granting full practice authority, particularly among organized physician groups asserting that their specific preparation is essential for quality of care (Devi, 2011), since 2010, eight states have removed statutory barriers that prevented nurse practitioners from providing care to the full extent of their education and training (CCNA, 2015). In these states, nurse practitioners may now practice without supervision by a physician and have prescriptive authority. Consumers in thirty states continue to face restrictions to access primary care from qualified nurse practitioners. Consumer advocacy groups, such as AARP, and nursing organizations continue efforts to dismantle these barriers.

At the same time, the issue of geriatric expertise in primary care is of even greater importance. In 2008, the American Association of Colleges of Nursing (AACN) Board of Directors endorsed the Consensus Model for APRN (Advanced Practice RNs) Regulation: Licensure, Accreditation, Certification & Education, providing national standards, which include requiring gerontological preparation for all nurse practitioners caring for adults (AACN, 2015).

Long-term care

Consumer preferences have resulted in expanded alternatives to institutional settings (i.e., nursing homes) over the past two decades, including home-based services and supports, adult family–residential care homes, and assisted living. Older adults residing in these settings are living with multiple chronic conditions and functional impairments requiring regular care and attention from others (Caffrey et al., 2012). Yet, the presence of an RN is not always feasible, and direct care and community health workers deliver the majority of services and supports. Nurse delegation is a critical strategy to extend effective, consumer-driven care to a large proportion of the long-term-care community (Sikma and Young 2001, 2003).

Nurse delegation is supported by the IOM recommendation that each worker's knowledge and skills must be used as efficiently as possible, with more flexible roles and greater enactment of the full scope of practice at all levels (IOM, 2008). The Joint Statement on Nurse Delegation, published by the American Nurses Association (ANA) and the National Council of State

Boards of Nursing (NCSBN) (ANA and NCSBN, 2009), affirms the importance of delegation. Yet barriers exist to fully enacting nurse delegation in many states, including reimbursement, regulations, and educational preparation of RNs, and direct care and community health workers (NCSBN, 2005; Reinhard and Quinn, 2004; Reinhard et al., 2006).

Prior to legislation allowing nurse delegation to inject insulin in assisted living settings, Washington State residents were forced to move into a nursing home based on this routine need alone, against their preferences and at greater cost to the system (Sikma and Young, 2003). Nurse delegation is not permitted in assisted living facilities serving older adults with dementia in California, limiting the ability of these settings to address this population's health needs, and resulting in unnecessary visits to emergency departments (Sharpp and Young, in press). As of 2009, regulatory agencies in thirty-three states, plus the District of Columbia, include jurisdictions with some type of regulatory provision for medication aides (Budden, 2011).

Nurse delegation poses important questions, such as the extent of healthcare delivery that can and should be delivered in community-based long-term-care settings, and the appropriate level of staff credentials to deliver services such as medication management and wound care (Mitty et al., 2010).

Washington State led the nation by formalizing and reimbursing nurse delegation. Evaluation of this policy change concluded that it brought unlicensed practices under RN supervision, demonstrated the safety and effectiveness of nurse delegation in assisted living and adult family homes, increased consumer and direct care worker satisfaction, and allowed better communication across the team, consumers, and family (Sikma and Young, 2003).

Delegation also is essential in nursing homes for quality and safety, where RNs routinely lead teams of licensed practical/vocational nurses and direct care workers. Unfortunately, high staff turnover across all levels of administrative, nursing, and other staff (American Health Care Association, 2014), inadequate training (Young et al., 2013; Siegel et al., 2008), and staffing (Harrington et al., 2000; Towsley et al., 2011), challenge the ability of RNs to effectively delegate in nursing homes.

Other Systems-Level Issues

Preparation and education. *Retooling for an Aging America* recommended geriatric education and redefined roles to meet the needs of older adults (IOM, 2008). Substantial investments in geriatrics have supported growth in evidence-based resources and clinical expertise. Yet the dissemination and adoption of this new knowledge lag, highlighting the importance of systems-level interventions to promote full use of available knowledge (Franklin et al., 2011). Health professionals caring for older adults need new skills in addition to clinical competence, including effective leadership, communication, and collaboration skills; an understanding of systems, change, and quality; healthcare business models; the ability to form new kinds of coalitions, teams, and strategic partnerships; use of technology, including health information systems; translational research and evidence-based practice; and, a strong commitment to engaging those we serve (President's Council of Advisors on Science and Technology, 2014; IOM, 2010). Health professions education now incorporates competencies in interprofessional collaboration, teamwork, and understanding the roles of others on the team (Interprofessional Education Collaborative, 2011).

Nurses supervise and delegate care in a variety of long-term-care settings, yet preparation for these roles is not part of basic nursing education, and little formal preparation is available beyond on-the-job training (Young et al., 2013; Siegel et al., 2008). Furthermore, the IOM report on improving quality in long-term care (Wunderlich and Kohler, 2001) cited the

importance of nursing management and leadership in the delivery of high-quality care, particularly in relation to the complex health needs of nursing home residents. Yet concerns persist regarding the lack of educational preparation for directors of nursing in long-term care to develop the leadership and management competencies needed to effectively oversee nursing services (Siegel et al., 2010). Leaders in new teams delivering care across systems that are under growing pressure to yield value need a new set of skills, blending clinical and business best practices with an entrepreneurial spirit to drive necessary innovations.

Barriers exist to enacting nurse delegation in many states, including reimbursement, regulations, and educational preparation of RNs.

Policy. Policies regulating individual professions and healthcare settings (e.g., assisted living, home health) pose barriers to enacting full practice that is person-centered, of high quality, and cost-effective. A number of federal policies and reimbursement practices also are important for eldercare. In some states, such as Washington, reimbursement for delegating nurses is available through Medicaid. The CCNA has been addressing conditions of participation for payment by the Centers for Medicare & Medicaid Services (CMS), encouraging CMS to modify proposed regulation to clearly state that qualified health professionals (such as nurse practitioners) be eligible for clinical privileges, admitting privileges, and medical staff membership with voting privileges. CMS expanded the term "medical staff" to include APRNs and now supports team-based and collaborative care for patients in programs such as the Chronic Care Management benefit (Brassard, 2012). A series of research studies demonstrated the value of transitional care (Naylor, 2012; Naylor, Kurtzman, and Pauly, 2009). And recently, CMS adopted policies to pay physicians and other qualified healthcare providers for coordinating Medicare beneficiaries' care transitions for thirty days following discharge from hospitals or skilled nursing facilities to their homes or assisted living facilities.

CMS barriers remain for consumers cared for by APRNs. CMS confers the Accountable Care Organization (ACO) attribution solely on the basis of physician usage patterns, and APRNs are not allowed to certify patients for Medicare payment of home health and hospice services. Allowing APRNs to certify home health and hospice services can potentially decrease costs, expedite treatment by eliminating the need for physician sign-off, and enable patient-centered healthcare teams to practice more efficiently (Brassard, 2012).

The Affordable Care Act of 2010 has the potential to address access, quality, and cost. Importantly, the push toward value-based purchasing has the greatest potential to cause innovations in care and systems. Financial models that move beyond fee-for-service for a single provider to reimbursement for outcomes at the team level, across settings, have greater potential to incentivize collaborative practice and organize cost-effective solutions for care—care that will mean the right person delivering the right care, at the right time. As payment reform unfolds, healthcare professionals' scope of practice will also evolve, toward positioning teams (including direct care and community health workers) to deliver effective, high-value care. Secretary Burwell of the U.S. Department of Health and Human Services accelerated the timeline for payment reform, expecting that by 2018, 50 percent of fee-for-service payments will be tied to quality and value through alternative payment models such as bundling or ACOs (U.S. Department of Human and Health Services, 2015).

Team communication and connection. Under healthcare reform, many professional organizations are rethinking healthcare deliv-

ery from a team perspective, optimizing the contributions of all members to address a population's complex care needs. The American Hospital Association (AHA) (AHA, 2011) proposed an accountability-based, primary care workforce model with the patient and family at the center, driving delivery design, and including members from a variety of disciplines with defined roles, all contributing to outcomes in a more cost-effective and coordinated way. Communication and coordination among the team members are core elements, and the goal is to match the demand of the clinical encounter with the most appropriate member of the team to deliver the desired outcome.

A major challenge in measuring outcomes across settings is the lack of common terms, definitions, and uniform data sets.

The earliest and most robust effort to achieve team care was the Program of All-Inclusive Care for the Elderly (PACE), established under Medicare with the 1997 Balanced Budget Act. PACE targets non-institutionalized frail and disabled persons who are eligible for nursing home care and dually eligible for Medicare and Medicaid funding. PACE interdisciplinary teams assess participants and deliver the full range of appropriate services. This approach removes the financial disincentives across providers, and unites the healthcare team around the goals of better long-term management in least restrictive environments (Wieland et al., 2000). Efforts are underway to expand this successful program for older adults who are not nursing home–eligible—the PACE Act of 2015 was passed in the Senate and awaits action from the House (U.S. Congress, 2015).

With greater focus on outcomes, innovations in team-based care are gaining renewed relevance and traction. These include the Transitional Care Model (Naylor, Kurtzman, and Pauly, 2009), which focuses on intensive management of the transition from hospital to home; the Interact II model (Ouslander et al., 2011), which is aimed at reducing nursing home transfers to hospitals; the Coleman Care Transition Intervention (Coleman, 2006), which focuses on increasing patient engagement in care; and, Care Management Plus (Dorr et al., 2007), which promotes comprehensive chronic disease management in primary care settings. These models share common strategies in leadership, team education, standardization of approaches, and deployment of the right person, at the right time, to provide care.

Technology can foster communication among the team and extend care capacity. Efforts to integrate and standardize information systems across settings and providers will improve access to timely, relevant information, promoting optimal care. Telehealth has particular relevance in resource-poor rural communities, for educational outreach to healthcare providers and informal caregivers, to facilitate communication between healthcare providers and distant caregivers, to provide access to specialists, and to improve consultation capacity (Goins, Kategile, and Dudley, 2001). Finally, assistive devices, ranging from low-tech gadgets that help with dressing, to mobility devices, to computerized monitoring and cueing programs for critical reminders (such as medications or activities), can enhance independence in frail older adults, increase home safety, and reduce injury risk. Medicare funding is available for many types of durable medical equipment.

Quality outcomes. A major challenge in measuring outcomes for older adults across settings is the lack of common terms, definitions, and uniform data sets from which to construct performance measures, as well as the absence of a national data repository to which all providers and settings contribute. While performance measurement, public reporting, and quality improvement within

discrete settings have advanced, measurement across settings lags and is vital to accomplishing optimal care for elders. Reimbursement performance measures require extensive testing for validity and reliability across populations. Few are able to capture the complexity of outcomes for older adults across settings (Young et al., 2011).

Finally, if value is defined by how a patient benefits, it is essential to include metrics that capture the patient experience, such as quality of life, function, depression, symptoms, perception of adequacy of preparation to manage care, confidence and motivation to manage chronic disease, capacity of family caregivers to contribute (Berenson et al., 2013), preferences for involvement in healthcare decision-making, and perspectives regarding treatment burden (Wolff and Boyd, 2015). Promising research is developing within the Patient-Centered Outcomes Research Institute to advance the measurement of patient-centered outcomes, both through deliberate and systematic engagement of patients in research design and outcomes prioritization, and through investment in methodological studies. Measuring patient-relevant outcomes not only assesses care value, but also can provide valuable information for clinicians to target conversations and strategies (Sloan, 2010; Spertus, 2008).

Conclusion

When considering services from the older adult's perspective, improvement starts with the health trajectory and care journey. Through that lens, the systems engineering question is how to improve quality and value across the usual boundaries and silos, assuring that the right person is available, at the right time, to provide person-centered care. The challenge is to design an interdisciplinary team and continuum of care that dramatically improve value. The changing landscape of healthcare, driven by population demographics and new care models that will expand practice beyond hospital settings requires comprehensive analysis of workforce needs beyond a focus on numbers of professionals. Future projections should take into account new configurations of person-centered practice that optimize contributions from a variety of professionals, and create the greatest access, quality, and value.

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