Local Health Improvement Plan (LHIP): Seniors Work Group

Final Report 2016

Volunteer, citizen-led advocacy efforts on behalf of Frederick County's poorest and frailest seniors have been well supported and enhanced by participation in the county's LHIP process over the last two years.

- Inclusion in the process put the needs of seniors on the table for discussion.
- Opportunities for collaboration, either between agencies or between LHIP projects and objectives, came to the forefront.
- The need for more data on seniors and better collection/dissemination of that data has helped drive discussion on overall health data and how it is presented to citizens and policy makers.
- Opportunities to explore external grant funding have become part of the ongoing conversation among organizations.
- The work of the County Executive's volunteer committees addressing senior needs and county-run senior services have been aided by insights gleaned from other LHIP work groups, especially Health Disparities and Dental.

LHIP Priority: Identification of and services for poor elderly in Frederick County.

Goal: *That no elderly in this county will have a health need that is unmet because of a lack of funds: including access to healthcare (including primary care, mental health care, and vision, hearing and dental), transportation, affordable housing, assisted living and nursing home care.*

Objective #1: Data Collection *(Collection of relevant data for elderly poor of Frederick County)*

Action Plan Strategies Included: Survey Meals on Wheels by volunteers by January 2015; Pull data from Health Department and Office on Aging and other by January 2015 and Identify others who can provide or help to collect data by January 2015.

LHIP Report 8/6/2015 Conclusion: Data collection continues to be uneven and decentralized among government, non-profits and for-profit providers. Even the Department of Aging does not collect and maintain data on seniors that can be used in planning by local organizations. In fact, in the process of locating data on seniors that could be used by the Health Disparities Work Group, it was discovered that even data used in the county needs assessment is out-of-date. In addition, health data is often not broken down by age in ways that would help in planning for the needs of very different groups, i.e., 55-65, 65-75 and 75 and

over. This is evident in FMH's *2013 Community Health Needs Assessment*. **Given the population growth in each of these age groups, more differentiation is needed and a central hub for data collection -- or at least an effort to collaborate on data collection for public view and use --- is needed.**

Sept 2015 - June 2016 Actions and Final Conclusion:

- The County Executive's appointment of the Seniors First Task Force placed some official teeth behind the drive to gather available data on senior needs and services from county-run services. The results of that effort will come forward in the summer/fall of 2016.
- In September of 2016, the FCHD undertook the big task of surveying all county health care providers (physicians, practices, therapy practices, etc) regarding the acceptance of Medicare and Medicaid, and whether or not they were accepting new patients and new Medicare and Medicaid patients. This updated information included as part of the 2012-13 Senior Needs Assessment document. It did not, however, separate out primary care services.
- The 2016 Community Health Needs Assessment, produced jointly by the FCHD and FMH, is a major step forward in health data collection and presentation. It also includes information from focus groups conducted by graduate students at GWU's Milken School of Public Health. The report provides more data breakdown by age and offers more comparison information. The section *Barriers to Care by Age* (page 161) provides additional information, including the note under "Major Findings - Common Themes" that "Medical management for the elderly population is also a major issue." (page 165)
- The growing focus on geriatric care at FMH as part of the effort to address the medical management issue, improve overall care, strengthen transitional care and reduce hospital readmissions, and refine patient use of EMS and ED services is leading to more extensive data collection on seniors. FMH is now looking at "hot spots" of EMS and ED use/admissions to target geographic areas of higher use and, in turn, determine what preventive and patient management options might be employed to improve health, link to other sources of support for the social determinants of health (SDHs), and mitigate crisis calls that could be avoided. Beginning in 2016, use of Community Health Workers (CHWs) in the hospital's Chronic Disease Management process should lead to compilation of much greater data on the SDHs of seniors and their care management issues. Likewise, FMH's contracting with physicians to perform home visits on frail, disabled and homebound patients, should provide FMH will far more and better data on these patients than is acquired simply when someone arrives at the ED via ambulance.
- **A central hub for data collection and analysis** has not yet been achieved, but the need is recognized and conversation towards this goal continues.

In conclusion, we are not much further along in the amount of data we actually hold in our hands, but we have moved the needle in achieving agreement about the importance of data-driven decision-making and therefore the need to collect and analyze data in a collaborative way.

Objective #2: Create Advocacy Group.

Action Plan Strategies Included: Create a 501(3) by Friends of Montevue by April 2014; Strengthen Commission on Aging with new administration to empower advocacy by Jan Gardner by summer 2015; Development of a plan to meet the needs of this group.

LHIP Report 8/6/2015 and Conclusion:
Results: Advocacy group created; plan development

A group of citizen volunteers formed a non-profit organization for the purpose of advocacy on senior issues (Fall, 2014): Advocates for the Aging of Frederick County, Maryland (AAFC).

Sept 2015 - June 2016 Actions and Final Conclusion:

- AAFC continues to expand its network of organizations, exchanging information on an ad hoc basis where no specific process exists. In this way, communication has grown between the FCHD (including LHIP and the AERS Program), FMH, the Office of the County Executive, the Frederick County Commission on Aging and a variety of area non-profits. Discussions are ongoing with FMH, the Commission on Aging and other non-profit organizations serving seniors in developing short- and long-term strategies for closing gaps in services, increasing data and service collaboration and maximizing resources. FMH is a key player, now devoting extensive resources to expanding community-based care and recognition of geriatric needs.
- AAFC hosted the Maryland State Secretary of Aging in a visit to Frederick in May 2016, inviting thirty key leaders, including the County Executive, to discuss the state plan on aging, Frederick-area initiatives and issues of concern. Those included the lack of funding for the Medicaid Waiver Program, potential loss of funding for the AERS Program at FCHD and transportation concerns.
  In follow-up, AAFC will begin the process of advocating for maintaining AERS funding by communications with state officials, including Secretary David Brinkley.
- After initial development of relationships with outside experts advising on planning for senior needs, including the proposed development of a hospital-based geriatric center to serve as a coordinating focus for senior health needs, AAFC has funded consultation by the Altarum Institute's Center for Elder Care and Advanced Illness, Dr. Joanne Lynn,

MD, Director (Washington DC), to guide a collaborative moving toward a pilot project addressing this goal.

- Along the same path, AAFC members and FMH leadership will be visiting JHU's PACE program and associated services for the frail elderly in July 2015. This follows-up on a relationship with JHU built through contacts of Dr. Joseph Berman, and a visit made by JHU staff to Frederick earlier in November/December of 2015. The same visit made a connection between AAFC and a local JHU family practitioner/gerontologist now participating in a JHU study of physician education to reduce falls among frail seniors.

8/6/2105 Results: Commission on Aging Strengthened

Sept 2015 - June 2016 Actions and Final Conclusion: Openings on the CoA have been filled, bringing a full contingent of active, interested citizens to the commission. The new president of the commission continues the advocacy of the previous leadership and is participating with AAFC on various committees. The joint CoA/Chamber of Commerce Business Task Force is addressing numerous issues, including caregiving and the workplace and senior transportation. A May 2016 forum on transportation brought together every known provider of senior transportation in the county for the first time. As a result, a subcommittee will a) continue conversation with the county Transit director and b) ask that the Seniors First committee recommend that the County Executive create an ad hoc senior transportation committee to the Transit Advisory Council in order to advocate for senior needs on both the state and local levels.

Objective #3: Development of a plan to meet the needs of the elderly in Frederick County.

8/6/2015 Results and Conclusion:
Among the recommendations of the County Executive's Senior Needs task force was the need for a new model of leadership for senior services in the county, with greater collaboration and better data collection as key needs.

While the county's planning is underway, Advocates for the Aged, FMH, the Health Department and other partners are providing the leadership needed to create and implement an overarching strategy that includes, but is not limited to:

- a geriatric center for focusing services in a client-centered process
- a spectrum of innovative and affordable housing options for low-income seniors (including expansion of subsidized assisted living)

- expanded case management services to increase quality of life, minimize hospitalization and readmissions, encourage aging in place where possible and maximize human and capital resources
- development of financial resources to meet the needs of the growing senior demographic while balancing other community demands

Sept 2015 - June 2016 Actions and Final Conclusion:

- In September 2015, the County Executive appointed a Seniors First task force charged with making recommendations to her on how county-run senior services could be redefined and realigned to meet the growing and changing needs of the county. That report will be presented to her in summer, 2016. Two members of AAFC have participated on that task force. Increasing data compilation and use, a recalibration of how resources are used and a reassessment of programs are among the issues under discussion.
- The geriatric center concept continues to be discussed, with FMH playing a significant role, as well as identifying a broad range of options and ideas for improving care and services.
- The issue of affordable housing for seniors has not been addressed in a major way by AAFC to date, however; the upcoming transition of Montevue Assisted Living back to county control will provide the opportunity for this issue to come to center stage as the use of Montevue's beds - and financial resources - is explored by the committee.
- As detailed in Objective #1, the expansion of case management services, a person-centered approach to care, minimizing ED use and hospital readmissions, etc., are being examined by AAFC and its partners.
- The issue of expanding financial resources must also be addressed in a complete way. To date, discussions have included options for changes in Medicaid, greater advocacy for state transportation funds, better use of county/state/federal funds through the Department of Aging, etc.