

Future of Health Care –Aging Services

Feb 13, 2006 Tradition

- The definition of aging has changed—classical thinkers –more modern ones Gail Sheehy
- Erik Erikson –other than Freud, perhaps our most important psychoanalyst and professor of developmental psychology, outline the 8 Stage of Man. In this seminal work, enormous emphasis on early developmental stages-precious little detail on the last stage of life, “Integrity vs. Despair.” Though enormous respect for Erikson, this perspective is outdated.
- Seniors today-very different self image than described by Erikson. Much more emphasis on continued growth. Ask 65+ individual if they feel they are old.
- This new paradigm of how we view seniors affects all sectors of society and how best to plan for services. To include :
 - Housing-style, amenities, size, location, (shift back to urban areas)
 - Financial planning (reflective of life expectancy-flexible spending)
 - Employment-concept of several careers-not necessarily related
 - Leisure/travel/lifestyle preferences. More options for younger seniors
 - Sexuality issues- changes in patterns due to new therapies/medicines
 - Marketing issues (cars, clothing, all products)
 - Chronological age vs. actual age (many rule exceptions)
- Selected demographics:
 - 65 + Population grows from 35 million (2000) to 70 Million (2030). In 2030, 1 in 5 Americans will be 65
 - Self reported health care of seniors as excellent:
 - 42% age 64-74
 - 35% age 75-84
 - 31% age 85 +
 - Life expectancy for seniors is now approaching 1 full generation

- # of “healthy” years for seniors age 65+ is now 12 years (somewhat short of the 14 year goal established by Healthy People 2000)

Major Influences

- State/Federal dollars-promote aging in place. Reduce funding for Inst. Care (more programs like Florida Seniors Choice)
- De-emphasis on institutional care-focus on H & CB care
- Must maintain vigilance:
 - Quality Assurance
 - Total available \$ must reflect State’s growth-cannot simply reduce \$ spending
 - Older American Act (Federal \$ for H & CB Programs) must increase
 - Independent assessment to determine if outcomes are satisfactory
 - Satisfaction surveys-must be responsive to consumer needs
- Increasingly complex system to navigate (AASHA & Transition Management concept (personal experience with system). Must be user friendly (Recent Part D experience –ominous implications)
- Technology –this will and has radically change the delivery of services (perhaps the most significant change in health care for seniors)
 - Effect of technology is already here and will continue to be more significant
 - Video conferencing (to bring families together –case conf etc)
 - Expanded opportunities for learning (lectures from around the world-self directed learning Tradition technology
 - Monitoring capacity: movement, bed transfer, mobility patterns, sleep, exit patterns)
 - Passive nature of collecting data
 - Solitaire (cognition embedded in software)
 - Electronic records- net effect –more patient care
 - Digitized records-now sent to other countries for reading (off hours)
 - Pill dispensing
 - Patient clinical profile-portable and centralized
 - Increased effectiveness of treatments (critical path, best outcome data mgmt)

However

- Must have informed consent (can be a challenge with disabled population)
- Confidentiality issues-granny cams, electronic records
- Emphasis on effectiveness and utility (avoid window dressing)
- Not a substitute for human contact and family involvement (consider to be one other available tool)