Key Landscape Factors Shaping Integration of Social & Health Factors

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HHS Context
About the Administration for Community Living (ACL)

• Principal agency in HHS to lead aging and disability programs
• Created in 2012, bringing together:
  – Administration on Aging
  – HHS Office on Disability
  – ACF Administration for Developmental Disabilities

• Reduce fragmentation and promote consistency in federal programs and policy addressing community living

• Enhance access to quality health care and long-term services and supports for older adults and people with disabilities

• Complement community infrastructure as supported by Medicaid and other federal programs
Our Mission
Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

Our Vision
All people, regardless of age and disability, live with dignity, make their own choices, and participate fully in society
WHY DOES INTEGRATION MATTER?
Projected growth in the older population

Figure 1: Number of Persons 65+, 1900 to 2060 (numbers in millions)

Percentage of People in the US with Disabilities, 2008-2015

Data Source: 2008-2015 American Community Survey, American FactFinder, Table B1810

Age Distribution in the US Population of People with Disabilities, ACS, 2015

Data Source: 2015 American Community Survey, FactFinder Table B1810
Integration especially matters for people with Medicare & Medicaid

• 11.4 million duals
  – 53% have 3 or more chronic conditions
  – More then 90% receive fragmented care
  – Their care accounts for a disproportionate 34% of Medicare costs and 33% of Medicaid costs

Source: https://www.chcs.org/resource/advancing-medicare-medicaid-integration-infographic/
**High risk, high cost individuals= Those with chronic conditions **AND **functional needs**

*Medicare enrollees with chronic conditions and functional limitations represent over half of Medicare’s highest spenders*

<table>
<thead>
<tr>
<th></th>
<th>All Enrollees</th>
<th>Top 20% of Medicare Spenders</th>
<th>Top 5% of Medicare Spenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk, high cost</td>
<td>15%</td>
<td>46%</td>
<td>61%</td>
</tr>
<tr>
<td>individuals= Those</td>
<td>48%</td>
<td>41%</td>
<td>32%</td>
</tr>
<tr>
<td>with chronic conditions</td>
<td>31%</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>AND functional needs</td>
<td>7%</td>
<td>1%</td>
<td>7%</td>
</tr>
</tbody>
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Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.
Healthcare’s Blind Side

• 2011 RWJF survey of 1,000 primary care physicians
  – 85%: Unmet social needs directly contribute to poor health
  – 4 / 5 not confident can meet social needs, hurting their ability to provide quality care
  – 85%: Patients’ social needs are as important to address as their medical conditions
  – 76%: Wish the health care system would cover the costs associated with connecting patients to services that meet their social needs if a physician deems it important for their overall health.

Successful models for meeting the needs of “high need” patients (*National Academy of Medicine*)

- Targeting according to level and nature of function
- Tailoring requirements: Care attributes, service setting, delivery features, organizational culture
- Social services factored centrally into patient and care-partner specific needs
- Service linkages among health care system, social, economic, and behavioral programs
- Payment alignment

Transitions & beyond: What kinds of services do older adults and persons with disabilities need?

9,053 people connected to 12,131 services and supports (n= 30 sites in 14 states between April – September 2013)

Data Source: Aging and Disability Resource Center Semi-Annual Report Fall 2013
The critical role of CBOs in delivery system reform

Managing chronic conditions
- Chronic disease self-management programs (CDSMP)
- Diabetes self-management
- Nutrition programs (counseling, education & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

ACL
- Evidence-based care transitions
- Person-centered planning
- Peer supports
- Self-direction/self-advocacy tools and resources
- Chronic disease self-management
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education

Preventing hospital (re)admissions
- Evidence-based care transitions
- Care coordination
- Information, referral & assistance/system navigation
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Nutrition programs (counseling & meal provision)
- Caregiver support
- Environmental modifications
- Housing assistance
- Personal assistance

State aging & disability agencies
- Transitions from nursing facility to home/community
- Person-centered planning
- Self-direction/self-advocacy
- Assessment/pre-admission review
- Information, referral & assistance/system navigation
- Environmental modifications
- Caregiver support
- LTSS innovations
- Transportation
- Housing assistance
- Personal assistance

Community-based aging & disability organizations
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education

Diversion/Avoiding long-term residential stays
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education
HOW IS ACL FOSTERING INTEGRATION?
• NWD systems put the focus on the person and provides infrastructure to support the collaboration of local service organizations to make access to critical services more efficient and person-centered.

• The four primary functions that drive and help build a NWD System include:
  – Public Outreach and Coordination with Key Referral Sources
  – Person Centered Counseling (PCC)
  – Streamlined Access to Public LTSS Programs
  – State Governance and Administration

https://nwd.acl.gov/resources.html
ACL, in partnership with foundations, is providing aging & disability organizations with the tools they need to partner and contract with health care payers and providers in delivery system reform.
Person-centered Thinking and Practice

- Environmental scan
- Measure development
- Training development
- Community-level interventions
For more information:
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