Strengthening Services for Older Adults through Changes to the Older Americans Act

RECOMMENDATIONS FOR THE REAUTHORIZATION OF OAA 2011
A REPORT FOR THE ADMINISTRATION ON AGING (AoA)

Prepared by The Social Work Leadership Institute of The New York Academy of Medicine and The National Coalition on Care Coordination
Strengthening Services for Older Adults through Changes to the Older Americans Act

Since 1965, the Older Americans Act (OAA) has stimulated the development of coordinated services and financing for older adults. The Act will be considered for reauthorization in 2011. With the passage of the Patient Protection and Affordable Care Act (PPACA), AoA has an immediate opportunity, through the implementation of the PPACA and reauthorization of the OAA to strengthen its role with the Center for Medicare and Medicaid Services (CMS), and work toward new models of care that effectively link health and medical services with long term care and social supports. Through its existing service provider network, including Area Agencies on Aging, Aging and Disability Resource Centers, and National Family Caregiver Support Programs, the AoA will be able to make a significant contribution to models of care that successfully meet the needs of a growing population of vulnerable older adults with multiple chronic conditions.

The National Coalition on Care Coordination (N3C) (Appendix A) and the New York Academy of Medicine were encouraged by the Administration on Aging (AoA) to develop recommendations that consider how to strengthen care coordination in the 2011 reauthorization of the Older Americans Act. We are pleased to offer the following recommendations that will enhance provisions for care coordination that link health/medical and long-term care and social support services. These recommendations build on evidence and best practices already established in support of care coordination. Recommended changes are in the following areas:

- Aging Disability Resource Centers (ADRCs)
- Title II: Declaration of Objectives: Definitions
- Title III: Grants for State and Community Programs on Aging, the National Family Caregiver Support Program
- Title III: Area Agencies on Aging (AAAs)
- Title III: and potential Research, Training and Demonstrations
- Title IV: Activities for Health Independence and Longevity.

*N3C Specific Amendment Recommendations

Based on the analysis of AoA programs providing care coordination services, and in keeping with AoA’s request for specific amendments to be included in the reauthorization of the Older Americans Act, the following proposed changes are based on the principals that care coordination must be assessment driven, include a comprehensive care plan, require ongoing evaluation, utilize a qualified care coordinator, and be client centered and widely accessible. The proposed changes also include the recommendation that the “Yardstick” for Better Care as established by the
Campaign for Better Care, and led by the National Partnership for Women & Families, which highlights core elements of patient-centered practices, be incorporated as a baseline for these recommendations. The goal of the Campaign for Better Care is to ensure that the health care system provides the comprehensive, coordinated, patient and family-centered care that older adults with multiple chronic conditions want and need. (Appendix B).

**Amendment to Title II: Declaration of Objectives: Definition**

The Act should be amended to include the following definition of care coordination for AOA programs, including: Area Agencies on Aging (AAAs), Aging Disability Resource Centers (ADRCs), and the National Family Caregiver Support Program.

- Care coordination should include a strength-based assessment of both the client and caregivers needs, and must be culturally relevant.
- The care coordination plan should be developed to address the older adult’s medical and social needs and supports, and to span all care services.
- Care coordination programs should establish or strengthen ongoing relationships and include periodic evaluations of the care plan with older adults and their caregivers.
- Care coordination must be client-centered with the involvement of the care coordinator, older adult, and caregiver.
- Care coordination should be a dynamic process with the care coordinator, older adult, and caregivers working together to identify needed services as the condition of the older adults change.
- Care coordination should be available based on choice or need to all regardless of insurance coverage.

Strongly encourage state and Area Agencies on Aging (AAAs) to integrate care coordination into their plans. The Administrator of CMS should be required to coordinate efforts with the Assistant Secretary for the Administration on Aging to develop ways to incorporate care coordination for older adults with multiple chronic conditions who have health/medical and long-term care and social support needs. These efforts might include developing interagency partnerships to implement demonstrations and pilots, initiated by either AoA or CMS. Efforts should include the promulgation of best practices on care coordination that could be disseminated to health/medical care entities and to state and area agencies on aging which would be jointly involved in developing care coordination services within their respective states and communities.

The ADRC should include the definition (as identified in the section above Amendments to Title II (Title II, Administration on Aging Definition) of care coordination established by NYAM and adopted by N3C. This focus should include an interdisciplinary approach to integrating long-term care and social support services.
To require the Assistant Secretary to establish a standardized process that Area Agencies on Aging and state units on aging can use to build and improve linkage of long-term care and social support services to health/medical services.

**Amendments to Title III: Grants for State and Community Programs on Aging**

AAA’s should publicize the services they provide to health/medical care entities so that these entities can actively work with the AAA’s to improve care coordination on behalf of older adults.

Require AAAs to develop task forces in partnership with health/medical care entities in their communities, to create and submit to the AAA and to AoA an implementation plan to better coordinate health/medical services with long-term care and social support services.

Strongly encourage all AAAs and their grant recipients (providers of nutrition, supportive, caregiver support, disease prevention/health promotion services and other services) to: have staff members who are knowledgeable about eligibility and application procedures for neighborhood, city, state and federal programs and benefits for which older adults may be eligible (including, programs not designed specifically for older adults, like food stamps); offer to screen all participants for eligibility for entitlement and benefits; have capacity to enroll participants in such benefits or entitlements electronically, to assist with paper applications, or, at a minimum, provide effective referral to an agency to assist with enrollment.

**Amendments to Title IV: Activities for Health Independence and Longevity**

**Demonstration Authority**

AoA should incorporate new programs that would test various models of care coordination for older adults. This might include testing models that would assist AAAs and ADRCs to extend their expertise in supportive services planning and delivery to health/medical care entities that are involved in developing new models of care coordination that are part of the Patient Protection and Affordable Care Act. These health/medical care entities might include primary care practice, organizations (that are identified as patient centered medical homes), hospitals, and others. On the Assistant Secretary’s authority, require that demonstration grants give first priority to funding AAAs that have shown expertise in developing care coordination services for older adults with health/medical care entities. On the Assistant Secretary’s authority, require that AAAs testing care coordination models work with entities with research expertise to evaluate such programs.

Strongly encourage the Assistant Secretary to disseminate best practices on care coordination for older adults with multiple chronic conditions and long-term care and social support service needs. In addition, the Assistant Secretary should be strongly
encouraged to develop appropriate training curriculum that state and area agencies on aging can use to implement care coordination initiatives.

BACKGROUND FOR RECOMMENDED AMENDMENTS

Care Coordination: Development of Evidence and Best Practices

The New York Academy of Medicine (NYAM) has been advancing the health of people in cities since 1847. An independent, non-profit organization, NYAM addresses health challenges facing the world’s urban populations through interdisciplinary approaches to policy leadership, education, community engagement and innovative research (Appendix C). Through its Social Work Leadership Institute and the N3C initiative, NYAM focuses on policies that improve coordinated delivery of health and social services as a means to overcome fragmentation and poor quality of care.

Our findings illustrate that care coordination that is focused solely on medical care overlooks the importance of integrating medical treatment with long-term care needs. It is commonly expected that older adults, particularly those with multiple chronic conditions, need an integrated approach to care; this is essential to improving health outcomes, maintaining functional status, and supporting the ability of vulnerable older adults to remain within the home and community.

Prior to recommending specific policies, NYAM completed research to understand the evidence that exists in support of care coordination. Through our research at the local, state and national levels, we have had numerous opportunities to analyze existing programs and identify the essential components of care coordination, and begin to articulate reimbursement strategies that will support reform. The ultimate goal of our work is to advance policies that will improve care for high-risk populations of older adults with multiple chronic conditions.

In 2008, NYAM was commissioned by the New York State Department of Health and the State Office for the Aging to develop a blueprint for care coordination in New York State. NYAM convened stakeholders from a wide array of organizations involved in health, aging and long-term care to achieve this work. This led to the following definition of care coordination:

- Care coordination should include a strength-based assessment of both the client and caregivers needs, and must be culturally relevant.
- The care coordination plan should be developed, addressing the older adult’s medical and social needs and supports, and spanning all care services.
- Care coordination programs should establish ongoing relationships and periodic evaluations of the care plan with older adults and their caregivers.
- Care coordination must be client-centered with the involvement of the care coordinator, older adult, and caregiver.
- Care coordination should be a dynamic process with the care coordinator, older adult, and caregivers working together to identify services.
• Care coordination should be available based on choice or need to all regardless of insurance coverage.

Our work done for New York State provides an in-depth analysis of how current approaches to care coordination best serve the needs of older adults and provides a framework for New York State to implement care coordination programs (Appendix D).

As an extension of this work to the national level, in the fall of 2008 NYAM engaged in a partnership with the American Society on Aging (ASA) to establish the National Coalition on Care Coordination. The primary goal of N3C is to bring together leaders in health, aging and long-term care to build consensus on approaches to care coordination and work together to improve care for older adults with chronic medical conditions. This work includes:

- Synthesizing the existing research on care coordination models focused on the frailest and most vulnerable elderly. This work also explores effective staffing models based on interdisciplinary collaboration.
- Examining financing options for public sector and private payers to support care coordination services. We work with experts in the field to articulate options for testing and implementation.
- Building evidence to identify best practices that will provide integrated care for different populations according to level of need.

The initial output of this coalition was commissioning and broadly disseminating two reports: “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses,” authored by Randy Brown of Mathematica Policy Research, Inc. and “Structuring, Financing, and Paying for Effective Chronic Care Coordination,” by Robert Berenson, MD, a Senior Fellow at the Urban Institute and an expert in Medicare policy, and Julianne Howell, PhD, an independent technical consultant to The New York Academy of Medicine’s Social Work Leadership Institute and the Centers for Medicare & Medicaid Services (Appendices E and F).

Evidence for Care Coordination

Our review of the evidence shows that a decade of research and demonstrations has helped to develop evidence regarding care coordination interventions that are effective in achieving both improved beneficiary outcomes and reduced expenditures. Much of the evidence has focused on medical care and transitions among care settings, in particular from hospital to home. While this work has been useful in establishing the efficacy of care coordination in a more narrow sense, more work remains to be done on understanding how linking health and social services helps older adults achieve improved health outcomes and functional independence.

In recent years there have been two major reports authored on effective models of care coordination: one by Dr. Chad Boul, an expert on integrated care at the Johns Hopkins School of Public Health, and another by Randall Brown of Mathematica. Research by
both of these experts highlights common elements among different care coordination models that are essential to producing positive outcomes. Some of these commonalities include:

- Interdisciplinary approach
- Transitional care between settings
- Comprehensive geriatric assessment
- Ongoing evaluation and monitoring
- Self-management of chronic disease
- Caregiver support

Work continues in this arena, and preliminary findings presented by Dr. Cheryl Schraeder Director, Policy & Practice Initiatives, Institute for Healthcare Innovation, UIC College of Nursing and Health Systems Research Center and Randall Brown of Mathematica at the 2010 ASA Conference on Aging indicate that effective interventions should include assessment of the full range of medical, functional, and social issues found among older persons with multiple chronic conditions (Appendix G). Implementation of the programs and practices that integrate health services, long-term care and social support services hold the promise of improving health outcomes, delaying or preventing the need for institutional care, and reducing the need for costly hospital admissions and readmissions by helping older and adults and their caregivers navigate the range of services available within a community based setting.

As programs develop further it would be important to utilize the “Yardstick” for Better Care developed by Campaign for Better Care of the National Partnership for Women and Families, and their framework for Patient Centered Practice as a basis for developing and testing new models (Appendix B).

In summary, care coordination programs that integrate health, long-term care and social support services must continue to be evaluated and refined so that these approaches to care can be more widely disseminated based on their ability to meet consumer need and achieve the dual aims of improving the quality of care while controlling costs. Capitalizing on this reauthorization of the OAA and the pivotal role of the AoA and the aging network in providing home and community based, long-term care, and social support services for older adults, the AoA has the means at its disposal to support and foster the continued dissemination of care coordination models that integrate medical care with a broader array of services. Through its existing service provider network, including Area Agencies on Aging, Aging and Disability Resource Centers, and National Family Caregiver Support Programs, the AoA will be able to make a significant contribution to models of care that successfully meet the needs of a growing population of vulnerable older adults with multiple chronic conditions.
Appendices

Appendix A: National Coalition on Care Coordination

Appendix B: “Yardstick” for Better Care as established by the Campaign for Better Care, and led by the National Partnership for Women & Families.

Appendix C: New York Academy of Medicine Background

Appendix D: New York Academy of Medicine Care Coordination Framework

Appendix E: Brown, R. (2009) "The Promise of Care Coordination: An Analysis of Care Coordination Models that Can Reduce Hospitalization and Expenditures Among Medicare Beneficiaries and Improve Quality of Care."


Appendix G: Brown, R., Schraeder, C., (2010). Promising Models of Care Coordination/Care Management for Beneficiaries with Chronic Illness. Presentation commissioned by the National Coalition on Care Coordination for American Society on Aging Conference.
Bibliography


Brown, Randall (2009, March). The Promise of Care Coordination: An Analysis of Care Coordination Models that Can Reduce Hospitalization and Expenditures Among Medicare Beneficiaries and Improve Quality of Care. Prepared for the National Coalition on Care Coordination.


