Sustaining Networks

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Integrated Care Opportunities

- Accountable Care Organizations
- Community-Based Care Transitions Program (CCTP)
- Medicaid Health Homes
- Medicaid Managed LTSS
- Duals Financial Alignment Initiative
- State Innovation Models
It’s about chronic and functional limitations

Source: "LewinGroup analysis of 2006 Medical Expenditures Panel Survey, 2009"
Where do community-based organizations (CBOs) fit into integrated care models?

- Working with the state in an outreach/education/advocacy role
  - Assisting consumers with selecting plans
  - Monitoring quality of care provided to older adults and persons with disabilities (e.g., secret shopping and other forms of monitoring)
  - Individual complaint resolution (through ombudsmen programs)
Where do CBOs fit in? (continued)

• Contracting with integrated care entities (e.g., health systems, ACOs, managed/integrated care plans) as part of their long-term services and supports (LTSS) provider networks
  – Offering packages of services such as: care and transitions management, assessment, options counseling, person-centered planning, chronic disease self-management and other evidence-based programs, nutrition, transportation, caregiver support, benefits outreach and enrollment
  – More formal network building at the community level is critical, as such associations/networks can provide a critical mass in terms of the types of services offered, expand the geographic reach of any single organization, and offer economies of scale for common business functions.
Where do CBOs add value?

Managing chronic disease
- Stanford model of chronic disease self-management
- Diabetes self-management
- Nutrition counseling
- Education about Medicare preventive benefits

Preventing hospital (re)admissions
- Evidence-based care transitions
- Care coordination
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Caregiver support

Avoiding long-term NF stays
- Nursing facility transitions (Money Follows the Person)
- Person-centered planning
- Assessment/pre-admission review

Activating patients
- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Benefits outreach and enrollment
- Employment-related supports

ACL
- State aging & disability agencies
- Community-based aging & disability organizations
Where is ACL investing?

• ACL is working to build the business capacity of state and community-based aging and disability organizations for partnerships with integrated care
  
  — Working with national partners (n4a & NASUAD) to provide training and technical assistance (TA) for aging and disability networks on issues related to integrated care, and assess aging and disability networks’ involvement in these systems
  
  — Leveraging TA resources to offer targeted technical assistance to a learning collaborative of community-based integrated care networks interested in contracting with integrated care entities
  
  — Working with philanthropic partners (The SCAN Foundation, the John A. Hartford Foundation, Grantmakers in Aging and more) to coordinate activities where possible, leverage resources, share learnings
Business acumen learning collaborative networks

- Partners in Care Foundation (CA)
- San Francisco Department of Aging and Adult Services (CA)
- Healthy Aging Regional Collaborative (FL)
- Elder Services of the Merrimack Valley (MA)
- The Senior Alliance and the Detroit Area Agency on Aging (MI)
- Minnesota Metro Aging and Business Network (MN)
- AAAs of Erie and Niagara counties (NY)
- PA Association of AAA, Inc. in partnership with the PA Centers for Independent Living (PA)
- North Central Texas Council of Governments (TX)
For more information:

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