Older adults with complex, chronic conditions consume a significant and growing share of medical resources. The results of this investment can be less than satisfactory for the person receiving care and stand in opposition to our nation’s triple-aim goal for healthcare: better outcomes, better patient experience and lower cost.

Trends suggest that the number of high-cost, high-need older adults will grow while public and private resources will not.

**CRITICAL FACTORS THAT COMPLICATE CARE**

- **Multiple chronic conditions**
  Thirty percent of Medicare beneficiaries account for 80 percent of the costs.

- **Dementia and mental illness**
  These issues complicate care plans and service needs.

- **Transitions of care**
  Without coordination, transitions create risk and increase complications.

- **Non-medical roadblocks**
  Isolation, unsafe environments or little access to transportation contribute to poor health outcomes.

We cannot continue to do business as usual. We must chart new pathways of care within and across the health care and social service sectors.
Minnesota is already moving forward

The Minnesota Leadership Council on Aging wants to be a catalyst for increasing efforts already underway in Minnesota to address the needs of frail older adults. Minnesota has a long tradition of managed care in the private sector and Medicaid. Our state pioneered managed care for dual elders in its Minnesota Senior Health Options (MSHO) program.

More recently, Minnesota received funding from the Centers for Medicare and Medicaid Services (CMS) to implement its State Innovation Model initiative (SIM). Minnesota is using these funds to drive health care reform and to test the Minnesota Accountable Health Model. The goal of this model is to ensure that all Minnesotan have the option to receive team-based, coordinated, patient-centered care that facilitates access to medical services, behavioral health care, long-term care, and other services. The model will expand Minnesota’s current Medicaid Accountable Care Organization (ACO) demonstration and include 15 Accountable Communities for Health (ACH). These communities will develop and test models for integrating care across systems. See the Appendix for a map of SIM grantees.

In addition to MSHO and the SIM initiative, Minnesota’s Integrated Health Partnership (IHP) program is also facilitating integration between managed care and social service organizations to provide more comprehensive care approaches for Medicaid enrollees. Thus far, these types of partnerships have been encouraged but not mandated. ACOs have the option to include social service providers in shared savings arrangements.

Several other innovative collaborations and practice-change initiatives are underway or in development, including:

- **ACT on Alzheimer’s**, a multi-sector collective impact initiative, created best practice tools being adopted by health systems to train physicians to identify and diagnose dementia and to train care coordinators at both the provider and payer locus to connect patients and their family caregivers to community services and supports.

- **Silos to Circles** is a collaboration of health care providers, payers, housing agencies, aging services, quality improvement professionals, and mental health providers working together on shared priorities that will foster wholeness for the currently fragmented continuum. Focus areas are chronic disease, behavioral health, and community wellness.

- **Health system transitions programs and physician-led practice models** are delivering onsite care to frail seniors moving back to home or currently living at home and/or in assisted living settings. This care model consists of a team approach, regular physician/physician extender visits and proactive care. “Real time” physician access and ongoing communication with staff and family members through supporting technology are core components to these partnership approaches.

### Primary drivers of the State Innovation Model (SIM)

- Expansion of e-health
- Improvement of data analytics
- Practice transformation
- Accountable communities for health
- ACO alignment related to performance measurement and payment
Value of coordinated care

The medical and social service systems share common goals. They both want individuals to maximize their well-being and to avoid medical catastrophes that generate costs and suffering.

Although the evidence base for effective strategies to manage high-risk cases is still weak, some approaches offer promise. Virtually all interventions in this area are based on upfront investment with a belief that these efforts will save money downstream. Promising interventions also acknowledge the importance of the social determinants of health—availability of resources such as healthful foods and social services, social support and connection, socioeconomic conditions, transportation, public safety and more. They also recognize the need to fully integrate family caregivers in the care plan.

NATURE OF MULTIPLE, DYNAMIC TRANSITIONS IN CARE

Our complex care systems often require multiple transitions. The figure above depicts a typical pattern for a person with dementia. It illustrates how dynamic care can be. The numbers indicate the proportion of people who make a given transition.

Of persons with dementia discharged from a hospital, 52 percent go home without formal services, 27 percent go home with formal services, and 34 percent go to a nursing facility. Conversely, 60 percent of those in a nursing facility go back to a hospital and few go home.

Models of integration

Integrating medical and social care, or at least aligning these efforts, can take many forms. It may look different from the consumer and provider perspectives; and it might vary depending on who is paying for the care. Consumers want smooth transitions and coordinated care, yet public policy and other payment drivers make it difficult to meet this preference, especially for frail older adults with complicated needs.

Long-term services and supports (LTSS) and health care can be related in several ways:
- Coordinated efforts such as referrals upon discharge or in clinic.
- Joint ownership of programs and services. This might be accomplished through contracts for service between LTSS and health care providers. These arrangements could be exclusive or among several organizations.
- Merging of LTSS and health care providers into one entity or subsidiary.
- Expanded service development (LTSS becoming a health care provider or vice versa).
- Integrated care offered in housing units or other community-based locations.

Components of promising interventions

Promising interventions include some or all of these components:
- Shifting from a strategy that monitors patients based on return visits to health care providers to one that actively monitors and compares parameters to predetermined clinical trajectories. When a patient’s course deviates significantly, a provider intervenes at once.
- Developing meaningful, trusted relationships—an essential element for engaging high-risk patients in getting (and staying) involved in their own care.
- Utilizing the network of community-based LTSS to provide support and “wrap-around” care—whether the access point is the clinic or other means.
- Investing in strategies that value upfront effort to produce downstream savings.
- Involving the right people with the right knowledge—including respecting the talents and insights of community-care providers.

While it is widely recognized that fee-for-service payment (or productivity measures based on units of service) is inconsistent with proactive primary care, we cannot wait for the payment system to change.

Chronic disease management requires an investment strategy, wherein front-end effort is expected to yield dividends downstream from less intense service use. Some entity must bear that risk. Variations of managed care seem like the logical venue.
Key elements for successful integration

Technology to support systems, providers, and individuals

- A technology imperative that encourages both patients and clinicians to use technology when it is available, even when the likelihood of benefit is unknown.
- Communication/information technology that provides lesser-trained personnel with guidance and structure for observations and activities.
- Seamless and simple access to medical records to improve transitions of care.
- Core information—treatment goals, diagnoses, medications, functional and cognitive status, and information about family caregiver(s)—is readily available in an easily used format. Coordination does not necessarily require total integration of information systems.

Communication and respect across sectors

- Workers from different fields must be able to communicate. They need a common language and a mechanism for information exchange. Everyone needs to be heard.
- The observations and information of paid and unpaid caregivers need to be valued and acted upon. One model that has been promoted in nursing facilities might be applied more generally. INTERACT (Interventions to Reduce Acute Care Transfers) is a structured approach to empowering line staff to be heeded by nurses and nurses to be heeded by physicians. The concepts in this process of observation and empowerment can be replicated in a variety of settings as well.

Recognition and support for family caregivers

Family—and other informal caregivers—are the eyes, ears, and hands of much of the care provided. Replacing family caregivers would bankrupt the formal care system.

Family caregivers must be:

- Identified, supported and protected
- Treated as part of the care system
- Listened to and their questions addressed
- Involved in care decisions
Strategies for improved integration

Provide consumer-centric care that recognizes and prioritizes what the individual values.

- **Consumer-centric model of care.** Learn about the individual and provide care based on his or her values.
- **Health equity.** Ensure that all communities benefit from the integration of services in a culturally responsive way.
- **Mental health.** Include services for “hard to serve” populations including those with severe and persistent mental illness in integration strategies.
- **Dementia.** Ensure integration results in dementia-capable providers in all sectors.

Shift focus of care coordination from medical providers to community care providers.

- **Repolarize care.** Instead of putting technologically complex and highly specialized care professionals at the center, move to a model centered on an empowered care coordinator. This individual would develop an ongoing relationship with the patient. She or he would serve as the “general contractor,” securing and authorizing services of various medical and social services subcontractors (e.g., surgeons, procedurists, home care specialists, LTSS).
- **LTSS services.** Position long-term services and supports (LTSS) as a resource to primary care to support the growing number of older adults who use acute care inappropriately or who avoid acute care when it’s needed. This would be a first step to defining a role for LTSS in the “medical” market and establish credibility and relationships with primary care. This would require a defined entry point to LTSS that is efficient and effective in supporting primary care planning.
- **System navigators.** Look to LTSS agencies to supply cross-system navigators as part of an integrated approach.
- **Shift resources.** Shifting resources from acute care to supports needed at home that are in keeping with consumers’ choices and values for their lives.
- **Palliative care.** Position palliative care, often offered in partnership between medical providers and LTSS, as not only increasing quality of life but also securing potential cost savings in future health care costs.
- **End-of-life decisions.** These decisions require sustained relationships with a primary health care provider. LTSS can be a part of encouraging and supporting those relationships and initiating timely advance-care planning.
- **Joint efforts.** Intentional coordination of efforts by medical providers and LTSS providers could provide better results and help both systems be more responsive to consumers.
Strategies for improved integration (continued)

**Improve communications and information sharing among health care and social service organizations.**

- **Communication.** Train personal care workers to make systematic observations of their clients and to communicate changes in status to clinicians. Encourage clinicians to take action on even vague descriptions (e.g., Mrs. Jones doesn't seem herself today).

- **Information sharing.** Share records among medical and social care systems (at least the core essential information—diagnoses, medications, service use, functional and cognitive status). Equally important, share care plan goals.

**Recognize the value of and reward preventive care and consumer participation.**

- **Prevention.** Quantify preventive care (including oral health) as cost savings in future health care costs.

- **Patient participation.** Chronic disease management requires active patient participation. LTSS agencies can deliver low-cost evidence-based interventions that teach self-management and are well received by older adults.

**Address payment issues that stand in the way of effective integration of health care and community services.**

- **Data-driven payment.** Tie broad outcome data and metrics to payment.

**Develop pathways to achieve common goals and impact population health.**

- **Goals.** Engage organizations from all sectors in establishing a core set of goals at both the individual and societal level.

- **Scalability.** Minnesota is the land of 10,000 pilots. Replicate successful efforts beyond the demonstration stage.