Evidence-based interventions for addressing health concerns in later life

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Setting the Context: Public Policy

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Olmstead Decision

Public entities must provide community-based services to persons with disabilities when:

(1)such services are appropriate

(2)the affected persons do not oppose community-based treatment

(3)community-based services can be reasonably accommodated, taking into account resources available and needs of others receiving disability supports.

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The Integration Mandate

- Most integrated setting - a setting that enables individuals with disabilities to interact with persons without disabilities to the fullest extent possible.
- Provides individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities.
- Located in mainstream society

  Access to community activities and opportunities at times, frequencies and with persons of an individual's choosing

  Choice in daily life activities

  Opportunity to interact with persons without disabilities to the fullest extent possible.

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Other Policy Drivers

- Better Health, Better Care, Lower Cost
- Balancing Incentive Payments Program
- Participant-directed Services
- Money Follows the Person
- Caregiver payments and supports

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Setting the Context: Population-level Data

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National Core Indicators Project

- **The Adult Consumer Survey**

  - Completed with individuals age 18 and older who receive at least one paid service (in addition to case management) from the state DD agency.

  - Background Information Section, gathers data about the consumer from agency records.

  - In-person survey:

    Section I includes subjective questions only answered by the person receiving services from the state.

    Section II includes objective, fact-based questions that can be answered by the person or, if needed, a proxy respondent who knows the person well.

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NCI Approach

- States conduct face-to-face survey with randomly selected individuals receiving services (at least 400 per state).
- Families randomly selected for a survey by mail.
- Data used to create state reports about individual outcomes; health, welfare, and rights; staff stability and competency; family outcomes and system performance.
- A national report and a report for each state.

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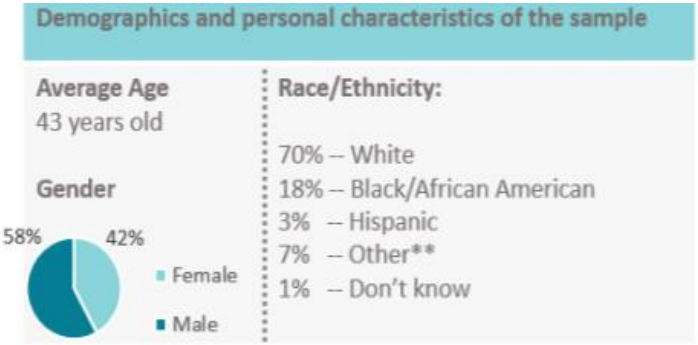
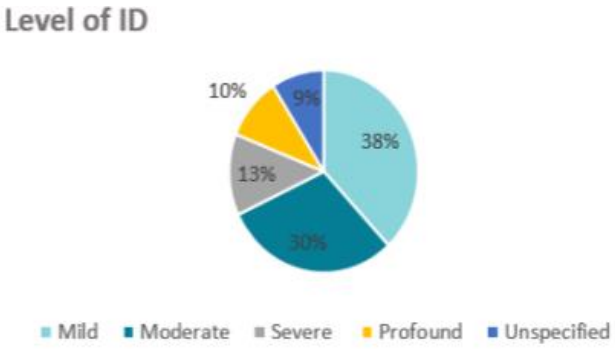
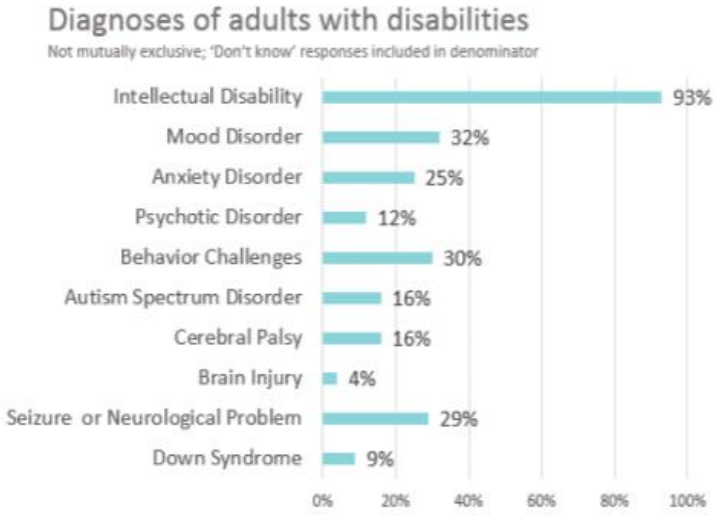
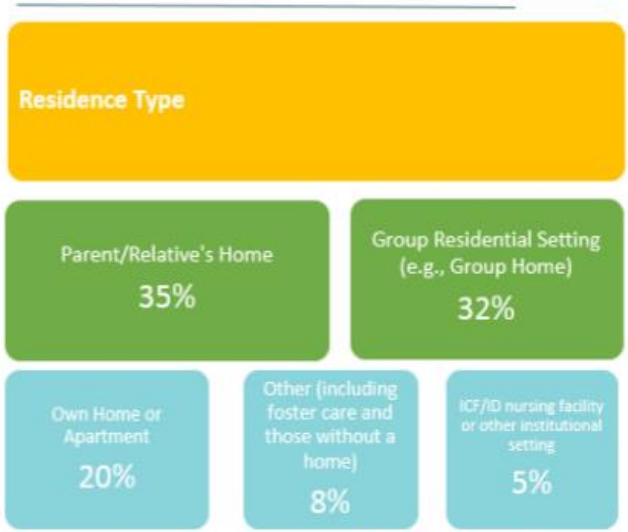
National Core Indicators: n= 17,862 from 36 states









*ACS: AL, AR AZ, CO, CT, DC, DE, FL, GA, HI, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO MS, NC, NV, NY, OH, OK, PA, RI, SD, TN, UT, VA, VT, WA, WI, WY

**Includes American Indian, Asian, Pacific Islander, two or more and other

NATIONAL CORE INDICATORS™

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NCI-Aging and Disability

NCI

- Community Inclusion
- Choice and Decision Making
- Relationships
- Satisfaction
- Service Coordination
- Work
- Self-Determination
- Access
- Health
- Medications
- Wellness
- Respect and Rights
- Safety

2009-10 National Core Indicators (NCI) Adult Consumer Survey Report

Descriptive and outcome data on 11,599 adults from 17 states and one sub-state entity.

7% (833 people) were age 65 and older.

Mean age 65 and older was 71.6 years/median age 70 years.

NCI-AD

- Community Participation
- Choice and Decision Making
- Relationships
- Satisfaction
- Service Coordination
- Care Coordination
- Work
- Self-Direction
- Access
- Health Care
- Medications
- Wellness
- Rights and Respect
- Safety
- Everyday Living
- Affordability
- Future Planning
- Control

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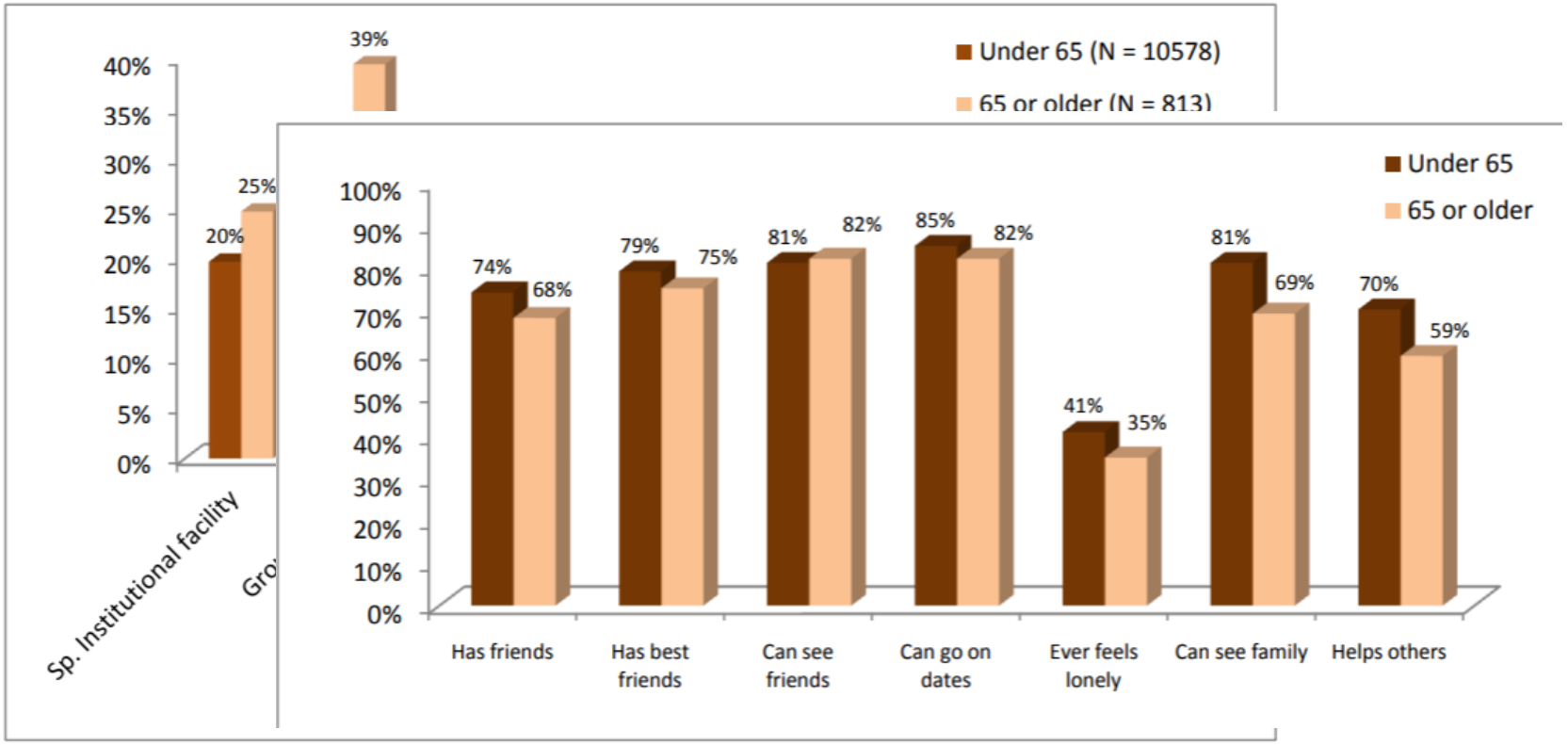
Where People Live and Relationships



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Behavioral Risk Factor Surveillance System (BRFSS)

- Ongoing since 1984, BRFSS - source of information about health-related risk behaviors associated with the leading causes of death in America.
- More than 500,000 adult interviews each year; weighting approaches ensure representativeness; valid and reliable measures: making it the largest continuously conducted health survey system in the world.
- Telephone and mail based surveying – core and supplementary modules – in 50 states – several states have included people with IDD using proxy reporters

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Combining NCI and BRFSS

- Adults with disability and with intellectual and developmental disability more likely to report being in poor health compared to adults without disability.
- Disability and intellectual and developmental disability conferred unique health risks and health care utilization patterns.

(Havercamp & Scott, 2015)

Using Medicaid Data

Longevity of people with ID has not increased in the last 10 years

(Lauer & McCallion, 2015)

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Setting the Context: Cost and Quality

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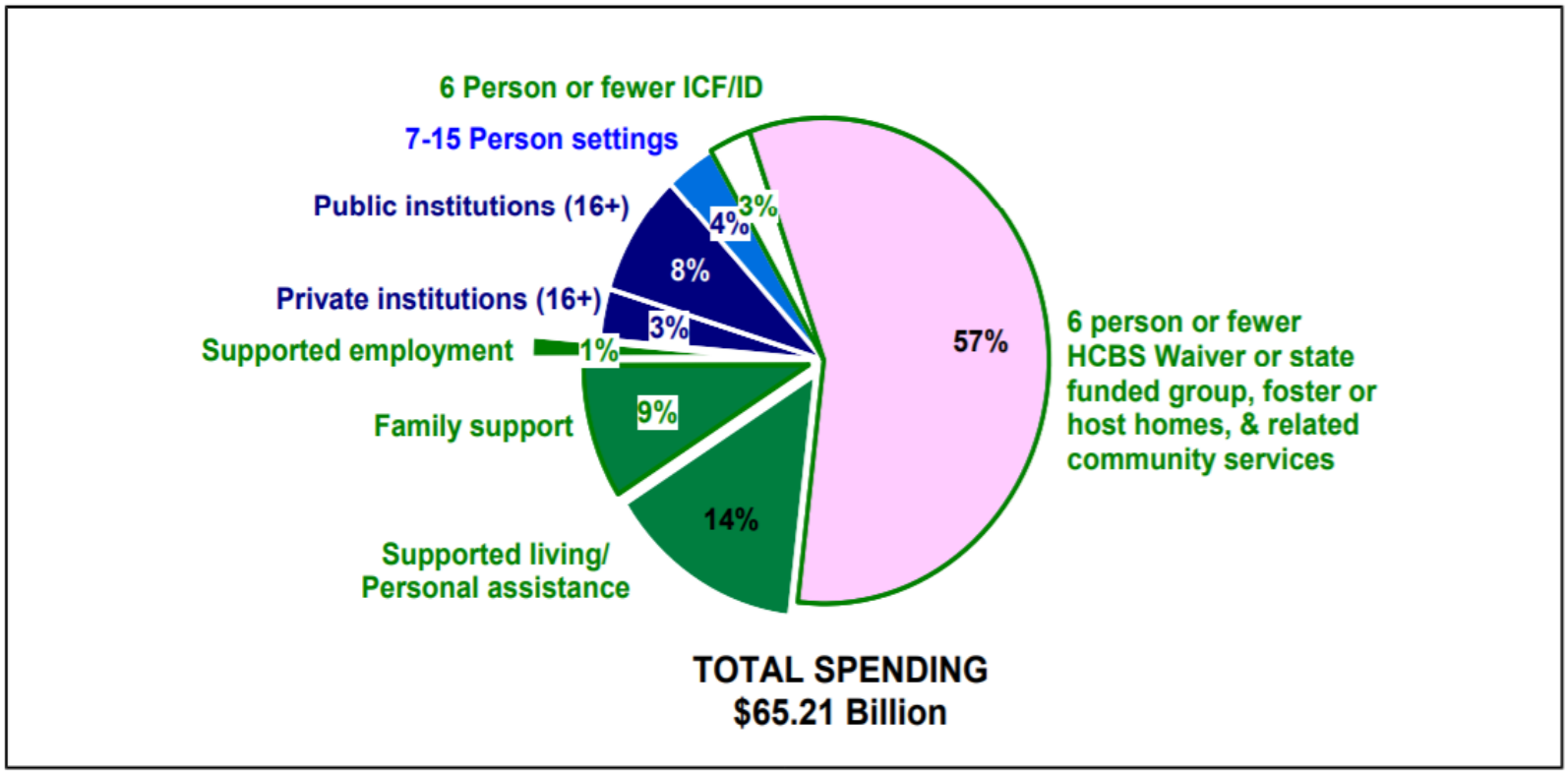
Where People Live and Where We Spend Money



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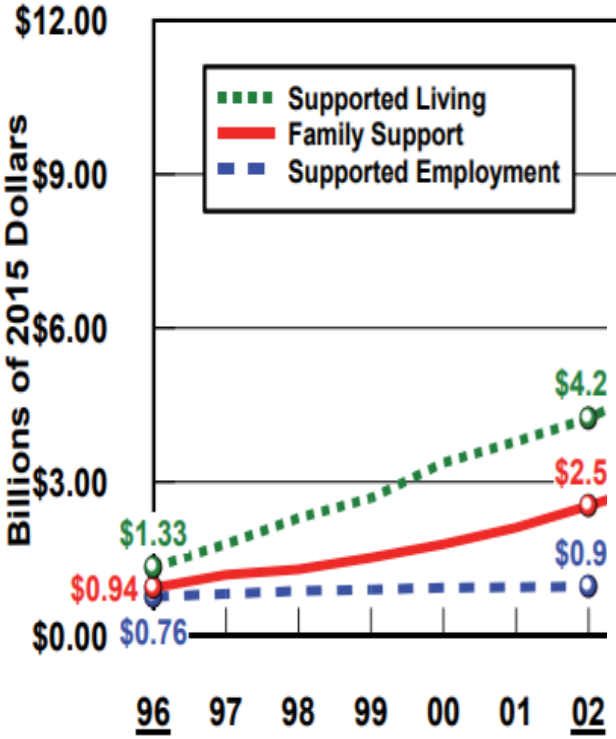
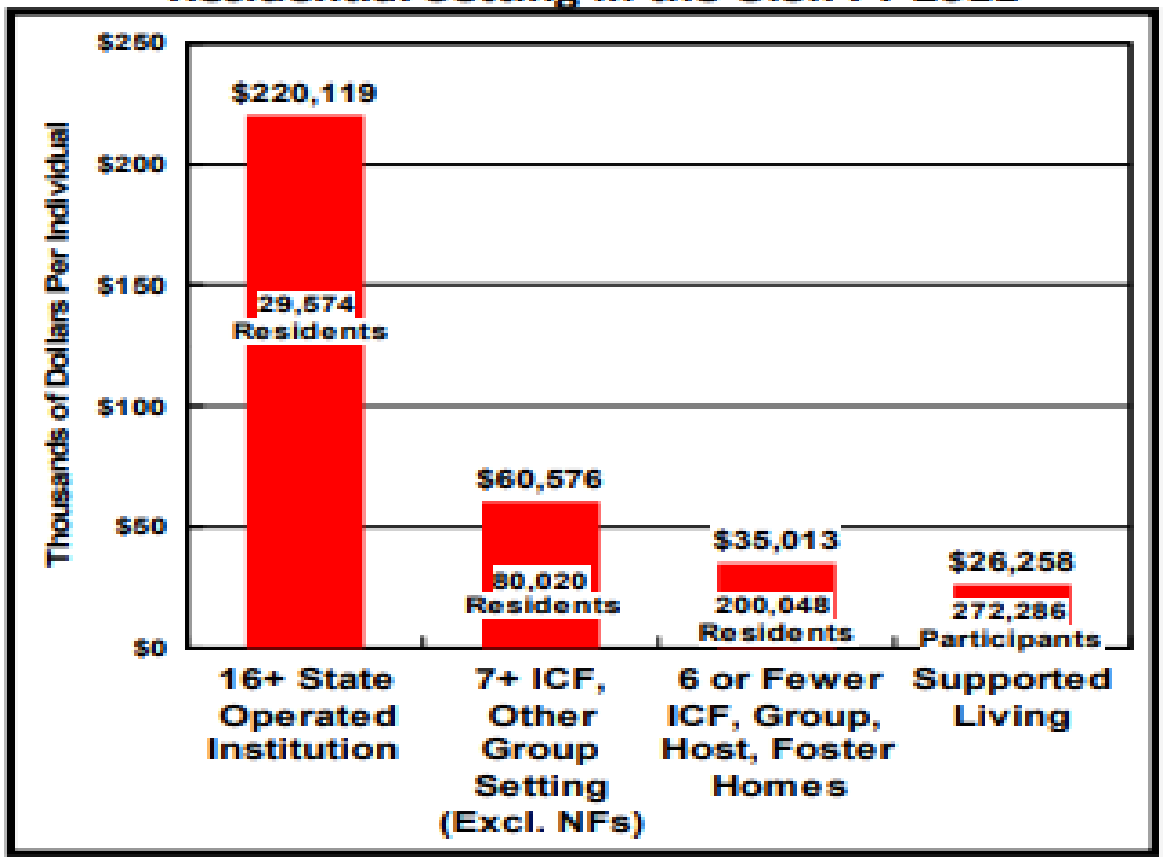
An Imbalance in Care Costs



4. Average Cost of Care Per Person by Residential Setting in the U.S.: FY 2011



An Imbalance in Health Costs

- Five percent of the population accounts for almost half (49 percent) of total health care expenses.
- The 15 most expensive health conditions account for 44 percent of total health care expenses.
- Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition
- Co-occurring mental health issues and intellectual and developmental disabilities add to the cost imbalance

AHQR, 2017

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Strategic Decisions

- Can we reduce the costs of those who are already high-cost?
- Can we prevent individuals at moderate cost becoming high cost?
- Can we improve everyone's health sufficiently that there are savings for all cohorts?
- Will wider availability of home and community based services AND population level health interventions reduce out of home needs and costs?

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The "Buckets" of Prevention

Bucket 3
community-wide prevention

- How do we improve population health in our states and communities?
- What is the best evidence of health *and* cost impact?
- What can we do that will begin to show results soon?

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Systematic Review Recommendations

- Better monitoring and treatment for chronic conditions common in the general population that are also experienced by people with IDD,
- An enhanced understanding of how to promote health among those in the IDD population who are aging,
- Addressing the health needs of people with IDD who are not part of the disability service system,
- Developing a better understanding of how to include people with IDD in health and wellness programs,
- Improving methods for addressing the healthcare needs in an efficient and cost-effective manner - better access to general medical care or specialized programs.

Anderson et al., 2013

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Building Healthy Lives: Annual Physical Exam, Flu Shot, Annual Dental, Cholesterol Screen

State	State	State	State	Overall In State	N
CO	CO	CO	CO	88%	363
GA	GA	GA	GA	86%	701
ME	ME	ME	ME	83%	473
MS	MS	MS	MS	83%	844
*NC**	*NC**	*NC**	*NC**	89%	801
*NJ**	*NJ**	*NJ**	*NJ**	86%	611
NCI-AD A	**NCI-AD**	**NCI-AD A**	**NCI-AD Average**	**86%**	**3793**

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Building Healthy Lives Using Evidence-based Approaches

- Care Transitions
- Self-management/health promotion
- Medication management
- Falls Prevention
- Reducing risk of diabetes and prediabetes
- Brain Health

- Integrated delivery/accessible materials/carer support and participation

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Data Driven Approaches

- Baseline data
- Are we collecting the correct data?
- Will the current “volunteer” model for data collection be successful?
- Value of comparisons to the general population?
- Have we the evidence-based interventions to make change?
- Do people with IDD need their own interventions?

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Thank You