Achieving Person-Centered Care: The Five Pillars of System Transformation

This policy brief establishes a basis for the critical system transformation activities necessary to produce a high-quality, person-centered system of care for older adults and people with disabilities.

Introduction

In 2001, the Institute of Medicine defined multiple aims for improving the health care system for the 21st century. Among these were to create a more person-centered system that respects and addresses the individual's preferences and needs and for individual values to guide the clinical care provided.[1] The 2011 National Quality Strategy acknowledges that the health system still has a long way to go to achieve this goal.[2] The current system continues to emphasize specific settings of care and providers without always recognizing the input or preferences of the individual. In contrast, a "person-centered" approach would see "a person as a multifaceted individual rather than the carrier of a particular symptom or illness [and] requires a partnership between the provider and the patient with shared power and responsibility in decision making and care management" (p. 10).[2]

In a previous policy brief on bridging medical care and long-term services and supports (LTSS). The SCAN Foundation presented its vision for a person-centered system of care for individuals with chronic conditions and functional limitations (see text box on page 2).[3] In the ideal person-centered system, the right providers would engage with individuals at the right time and right place with high-quality and appropriate services, involving family as appropriate, and creating a rational plan of care that puts the person's needs, values, and preferences first.

The majority of adults with chronic conditions and functional limitations are enrolled in either or both Medicare and Medicaid. As such, federal, state, and local policymakers and other stakeholders have a significant interest in identifying ways to improve the quality of care, reduce inappropriate use, and better manage costs for these individuals. The SCAN Foundation has developed a framework to organize the

An Ideal System:

Individuals with chronic health conditions and functional impairment would have access to a readily-available network of affordable options that provides high- quality care and supports, allowing these individuals to live well and safely in their homes and communities. The needs, values, and preferences of these individuals and their family caregivers would be regularly honored by the providers, organizations and delivery systems that serve them. Health care providers would be knowledgeable about long-term services and supports (LTSS), connecting people with available options to help them live functional lives. An array of community service providers would exist to help individuals navigate options for care and provide the tangible services. Community service providers, acting as the eyes and ears for health care professionals, would link accurate and timely information back to health care providers to enable individuals to use all services in the most appropriate and cost-effective manner. All providers would focus on making and maintaining key integrated connections between the main service platforms – primary, acute, behavioral, and rehabilitative care with LTSS – and place the individual in the center of the care experience. Overall, the right providers would engage with individuals at the right time and right place, involving family as appropriate and creating a rational plan of care that puts the person's preferences, values, and desires first.

Source: The SCAN Foundation (2012). Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk-Bearing Entities. Available at: http://www.thescanfoundation.org/bridging-medical-care-and-long-term-services-and-suports-model-successes-and-opportunities-risk. Accessed August 24, 2012.

medical care and LTSS systems with the aim of achieving a more integrated, person-centered service delivery system. We call this framework the "Five Pillars of System Transformation." This policy brief explains its critical elements and lays the groundwork necessary to produce high-quality, person-centered care, with a focus on the activities that are in the state's control to change as well as the role of other public and private sector stakeholders in supporting such a transformation.

The Five Pillars of System Transformation

Stakeholders historically engaged on issues around LTSS for years have described the problem of fragmentation in care delivery and how system redesign could improve the on-the-ground experience of care for vulnerable older adults and persons with disabilities.[4] The *Patient Protection and Affordable Care Act* (ACA) represented the first major initiative to break down the barriers that contribute

to system fragmentation and facilitate person-centered care.[5] For example, the Balancing Incentive Program (Sec. 10202) requires that eligible states adopt a universal assessment and a statewide single entry point system to improve access to LTSS. In addition, the ACA created a federal-level Medicare-Medicaid Coordination Office (MMCO) to better align these programs, which included provisions for technical assistance and funding to states that sought ways to better coordinate acute care, rehabilitation, behavioral health, and LTSS for those dually eligible for Medicare and Medicaid (sometimes referred to as "dual eligibles" or "Medicare-Medicaid enrollees").[6]

To achieve the goals proffered by the ACA and to meet the overall vision of high-quality, person-centered care, states have specific system transformation opportunities that are critical for success. These elements are:

- Administrative reorganization,

- Global budgeting,

- Universal assessment,

- Integrated information systems, and

- Quality measurement and quality monitoring.

Administrative Reorganization: Form Follows Function

State administrations play a critical role in supporting older adults and people with disabilities through a wide array of programs and services. In most states, administrative oversight of medical care and supportive services spans multiple agencies, departments, and programs through memoranda of understanding and other more informal arrangements, minimizing the capacity for a central decision-making authority to operationalize a vision of person-centered care as its focal point.[7] The administrative fragmentation borne from this state-level structure is further reflected at the local level where services are delivered. The labyrinth of departments, agencies, programs, and regulatory structures not only creates significant confusion and frustration for consumers and their families, but also affects access to care when services and supports cannot be located and acquired. Therefore, a key benchmark for creating a more person-centered system is minimizing the number of pathways individuals must navigate to get needed services, and having fewer administrative

structures can better facilitate this outcome.

Global Budgeting: Form Follows Funding

An individual's access to services is impacted by multiple federal, state, and local funding streams as well as one's own personal resources. For example, a person with chronic conditions and functional limitations who is eligible for Medicare and Medicaid (Medicare-Medicaid enrollee) has access to the following programs paid through separate funding streams: Medicare Parts A and B (or Part C – for those enrolled in Medicare Advantage programs) that cover primary, specialty, acute, rehabilitative, and behavioral health care; Medicare Part D for prescription medications; Medicaid that covers LTSS, medical copays and deductibles, additional health services (e.g., dental services, hearing aids, vision care); and Older Americans Act- or Rehabilitation Act-funded programs to support community living. No payer is singularly responsible for coordinating care or managing overall costs of care. Even within Medicaid, there are multiple funding silos among LTSS options, rather than one funding stream where

someone who needs services could access a range of home- and community-based waivered services, home health, State Plan optional services, or skilled nursing facility services. The separate, siloed funding results in individuals potentially enrolling in multiple, duplicative programs or missing opportunities to access services that may be preferred because they are challenged to navigate the whole system. As such, some individuals may end up in institutional settings rather than being able to access the more preferred and generally more cost-effective community-based options.[8]

Traditional public accounting practices allocate resources from multiple funding streams on a program or service basis without acknowledging that people frequently transition between settings and services with needs and preferences shifting over time. One solution is to integrate funding streams across programs into a single budget (often called "global budgeting" or "flexible accounting"). Flexible accounting practices can reduce or eliminate funding silos between disparate programs, allow greater investment in programs that more effectively or efficiently deliver care, and target spending in greater alignment with an individual's stated needs

and preferences.[9] Flexible accounting can encourage expansion of community-based care and achieve savings by reducing inappropriate institutional care and capturing those savings as part of the global budget to be repurposed toward community care (in more traditional accounting practices, excess funds would return to the state's general fund).

Managed care health plans, acting as risk-bearing entities, represent one pathway to the creation of a global budget.[3] A recent report by Mildred Consulting[9] examines budgeting practices in states with a history of Medicaid managed care, including managed LTSS. Of the four states examined (Arizona, Hawaii, Minnesota, Tennessee), all have intentionally-designed policies to allocate resources to increase the use of community-based care. One strategy employed involves putting the managed care health plans at risk for nursing facility care rather than carving out this service or providing "pass-through" funding to the facilities.[9] Other strategies include establishing a blended rate that builds in savings for the health plan if institutional utilization rates decline relative to historical trends, contractual requirements to implement a nursing facility

transition project (e.g., similar to Money Follows the Person), and contractual requirements for care coordination.[9]

While there has been no formal evaluation of the impact of flexible accounting practices on achieving person-centered systems of care, there is a correlation between the use of flexible accounting practices and having choice of setting of care and provider – a key feature of a person-centered system.[9,10]

Universal Assessment: A Common Architecture for Determining Needs and Preferences

Traditionally, multiple medical and LTSS providers assess the needs of enrolled individuals in different ways, using different instruments, with information used for different purposes – all of which lead to time expenditures for each program and "assessment fatigue" for the individual consumer. A person-centered system of care can only exist if the organizations that administer and oversee the system know the full scope of need and preferences for all eligible individuals and organize services based on that information.

Therefore, a uniform set of questions gathered for each participating individual (often called "universal assessment") can be used to evaluate their needs in a consistent manner and create a care plan tailored to each person's strengths, needs, and service/support preferences in an equitable manner. This information can be utilized not only for service delivery purposes, but also to support quality measurement by gathering information that can be used to construct quality measures related to LTSS. At the state level, universal assessment data can help program planners understand the needs of the population, support allocation of resources at the person, program, and state levels in a standardized way, and evaluate quality.

The universal assessment is valuable for identifying a person's needs and preferences, and connecting the individual to the appropriate services that can best meet those needs. At its core, universal assessment informs care planning and coordination through the assessment of an individual's physical and cognitive functioning, clinical conditions, strengths, deficits, and preferences for support. Gathering this information in a comprehensive way assists

in the development of a care plan and coordinating services that will support consumers and their families to maximize independence and achieve personal goals.

More than half of all states employ a universal assessment tool for at least some of their LTSS populations. A recent report by C.E. Reed and Associates examined the development and implementation of universal assessments across four of these states.[11] The authors offered several considerations for states pursuing universal assessment based on the experiences of these states:

• Consider utilizing an "off the shelf" tool that has already been tested and vetted in other ways, rather than creating an assessment from scratch, to ensure efficient use of scarce resources.

• Stakeholder engagement is critical in developing and implementing a universal assessment and should include consumers, families, care managers, home- and community-based service providers, health plans, and other stakeholders. Sufficient time should be built into the process to ensure a complete and fully engaged effort.

- Consider the downstream needs of the program, provider, and local/state planning perspectives, including what quality metrics and other performance monitoring initiatives are needed, and how those needs should be incorporated into the assessment.

- The time investment to develop, test, and implement a universal assessment can be substantial (three to eight years in the states interviewed).[11]

Integrated Information Systems: Essential for Effective Policy Evaluation, Resource Allocation, and Performance Monitoring

Integrated information systems are networks of person-level data (e.g., universal assessment, service or encounter data) that, when connected and effectively analyzed, create a comprehensive picture of the needs and service use patterns of individuals in the system and allow for the evaluation of the quality of care they receive at a specific point in time as well as across points in time. Integrated information systems are similar in concept to electronic health records that allow providers to access relevant health information, including pharmacy, lab results, and x-rays. An integrated information system can support provider access to appropriate information in a timely fashion and can reduce perennial problems individuals experience with multiple assessments.

A key step to creating an effective integrated information system is ensuring that the information flowing in is automated electronically and organized centrally. This should start with the universal assessment described above. Automation of assessment data will allow this information to be linked over time and connected with utilization and other administrative data that spans programs, providers, and local and state-level departments/agencies. Furthermore, the assessment automation and linkage in a central repository (as opposed to the common organization of data in agency or departmental silos) can be designed such that it is available in close to "real time," thus increasing its utility for quality improvement strategies and intervening where egregious quality concerns exist. Ultimately, the goal is to have data that represent an individual's needs and preferences, which flow from the person-level, where it guides care planning;

to the provider/program level, that supports program planning; and up to the state level, where it can guide statewide data-driven decision-making and policy development. Quality measurement and evaluation (discussed below) can then occur at all levels.

A recent report released by the California Medicaid Research Institute (CAMRI) illustrates the challenges of fragmented information systems.[12] In their effort to cultivate an integrated dataset to evaluate LTSS population characteristics, service use, costs, and outcomes, the CAMRI team developed an integrated and longitudinal database containing administrative and assessment data from both Medicaid and Medicare for those who used LTSS during a five-year period. To complete this task, the project team integrated almost 20 different data files from several different state-level departments and the federal government. The effort to create the dataset took well over two years, which included time to obtain approvals for data sharing and data use agreements across departments There is no automatic mechanism to update this linked dataset over time, thus the data are not current. A more person-centered system in which information drives planning and

decision-making is more likely to occur when data systems can be centrally organized with easy linkage across programs.

Quality: You Cannot Improve What You Cannot Measure

The first four pillars support accountable systems that measure, monitor, and identify areas for improvement in the quality of care provided in publicly-funded programs. Quality measurement and monitoring are critical to knowing if services are provided to the right people, in the right place and time, as well as whether a program or policy has achieved intended outcomes. Where deficits are detected, quality improvement efforts can intervene to achieve better care. However, quality improvement requires two important and intricately linked elements in order to move forward: quality metrics and an administrative system that supports evaluation.

It is not possible to improve what cannot be measured, and the currently available metrics are insufficient to evaluate the quality of a person-centered system of care. The National Quality Strategy identifies

success in a person-centered system not only by the appropriate management of clinical problems but also whether the individual "achieved his/her desired outcomes" (p. 10).[2] The traditional measures of the clinical quality of care focus on specific settings of care (e.g., hospital care, outpatient care, skilled nursing care) or on specific diseases (e.g., diabetes, heart failure) and are not sufficient to know if the system is evolving to better meet the individual's needs. In an integrated, person-centered system, these measures of quality are still important and would be augmented with additional measures that take a cross-provider or cross-setting perspective.

The current efforts to integrate care for individuals who are Medicare-Medicaid enrollees provide an important opportunity to define and test measures of a more person-centered system of care. The U.S. Department of Health and Human Services engaged the Measurement Applications Partnership (MAP) convened by the National Quality Forum to explore the challenges for quality measurement in the Medicare-Medicaid enrollee population. One of the goals of the MAP was to focus on the fragmentation in the current system and identify measures that

are aspirational and incentivize system change to achieve better alignment and less fragmentation.[13]

Quality in a person-centered context must reflect what is important to the individual receiving services and quality improvement efforts should center on those aspects of the system that reinforce person-centeredness. To date, there are few tested measures that evaluate a person-centered system. As identified by the MAP, measures should be developed that focus on quality of life and functional status, preferences for, and experience of, care as well as appropriate engagement in decision making, coordination of care, engagement of "non-traditional" partners outside the medical community such as community-based organizations that provide services and supports that foster community living, and ongoing management of chronic health conditions.[13]

System integration is not easily measured through traditional approaches; there is no single test or visit that reflects the totality of integration. Thus, traditional data sources (e.g., encounter data, lab data) will be insufficient for measuring system integration. Current quality evaluation efforts should be coupled with other methods and data sources that can capture

the experience of care from the individual's perspective. For example, health plan demonstrations of network adequacy should be linked with consumer self-reported experiences such as the ability to get an appointment when needed within a reasonable timeframe. Furthermore, the evaluation of care transitions will be critical to measure. Transitions from a hospital to home with family are important points in time where the appropriate instructions, home visits, telephone follow-ups, medication management, and connections to LTSS can determine the successful avoidance of further declines in health and/or hospital readmission. These are examples of the most appropriate types of measures that capture the extent to which the system is person-centered and meets the individual's needs and preferences.

The Pillars of System Transformation: The Whole is Greater than the Sum of the Parts

The five pillars of system transformation are highly synergistic. Administrative reorganization and global budgeting are interrelated in that organizing the administrative and

financing activities related to the pursuit of an integrated system of care under one "roof" can create greater efficiencies in the system and reduce the fragmentation that currently plagues state medical care and LTSS systems. Furthermore, universal assessment and integrated information systems are closely connected, as having common ways to evaluate need and share information across settings of care and providers can go a long way to better understanding who is served and to create an even playing field for service provision as well as support care management. Having universal assessment by itself can help to achieve the goal of equity and improve care planning in service provision at the person-level, but without an automated system in place to transmit that information to the provider, program, state, or federal levels, these data have limited use. Integrated information systems are critical to sharing this data for program planning as well as policy development.

The quality pillar of system transformation is highly dependent on the strength and interconnectivity of all the other pillars. Quality measurement is not just about having available metrics. If the data sources

necessary to produce those metrics are fragmented or do not exist, measuring system quality is simply not possible. Without a unified administrative structure, quality and other administrative data may lack a real home. Integrated care that is the cornerstone of a person-centered system cannot easily be achieved, and thus will not be favorably evaluated, without a global budget. Without universal assessment and integrated information systems, it is difficult to construct quality measures that have a common definition derived from common and accessible data points – the end result being an incomplete and inconsistent approach to program and policy improvement. Thus, person-centered care in an integrated system requires having a common measurement approach, a manner to collect this information systematically, data systems and an analytic process to understand what measures mean, and leadership to promote policy/programmatic changes that are necessary to support it.

States that create the capacity for any one of these pillars to exist will evolve a long way toward developing a person-centered system of care.

However, those that strategically interweave these pillars into a comprehensive whole have a much greater opportunity improve care for older adults and people with disabilities who count on this system, as well as improve the efficiency of the system, than any single effort in isolation might achieve.

References

1. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press; 2001.

2. U.S. Department of Health and Human Services. Report to Congress: National Strategy for Quality Improvement in Health Care; March 2011; http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf. Accessed August 17, 2012.

3. The SCAN Foundation. Policy Brief No. 6: Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk-Bearing Entities. 2012; http://www.thescanfoundation.org/bridging-medical-care-and-long-term-services-and-suports-model-successes-and-opportunities-risk. Accessed August 24, 2012.

4. Stone R. Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century. Milbank Memorial Fund; 2000.

5. Millenson ML, Macri J. Will the Affordable Care Act Move Patient-Centeredness Center Stage? 2012; http://www.rwjf.org/files/research/74054.5726.uipatientexperiencebrief.20120302.pdf. Accessed August 17, 2012.

6. Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office. About the Medicare-Medicaid Coordination Office. 2012; https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html. Accessed August 9, 2012.

7. The SCAN Foundation. Policy Brief No. 5: Transforming California's System of Care for Older Adults and People with Disabilities: A Look at the State's Administrative and Fiscal Organization. 2011; http://www.thescanfoundation.org/transforming-california%E2%80%99s-system-care-older-adults-and-people-disabilities-look-state%E2%80%99s. Accessed August 24, 2012.

8. National Council on Aging (NCOA), USA Today, United Healthcare. The United States of Aging Survey: National Findings. 2012; http://www.ncoa.org/assets/files/pdf/united-states-of-aging/2012-survey/8-3-12-US-of-Aging-Survey-Fact-Sheet-National-FINAL.pdf. Accessed August 10, 2012.

9. Hendrickson L, Mildred L. Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services: Recommendations for California. 2012; http://www.thescanfoundation.org/mildred-consulting-flexible-accounting-long-term-care-services-state-budgeting-practices-increase. Accessed August 24, 2012.

10. Reinhard S, Kassner E, Houser A, Mollica R. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. 2011; http://www.longtermscorecard.org. Accessed July 16, 2012.

11. C.E. Reed and Associates. Analysis of State Approaches to Implementing Standardized Assessments. 2012; http://www.thescanfoundation.org/ce-reed-and-associates-analysis-state-approaches-implementing-standardized-assessments. Accessed August 10, 2012.

12. Stone J, Newcomer R, Chattopadhyay A, Gilmer T, Chu P, Kao C, Bindman A. Studying Recipients of Long-Term Care Services and Supports: A Case Study in Assembling Medicaid and Medicare Claims and Assessment Data in California. 2011; http://www.thescanfoundation.org/california-medicaid-research-institute-studying-recipients-long-term-care-services-and-supports-case. Accessed August 24, 2012.

13. National Quality Forum. Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS. 2012; http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx. Accessed July 18, 2012.

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