# Involving Community Health Centers Could Improve LTSS Access

**As the population ages, health centers need to play a greater role in connecting residents to long-term services and supports as well as having more of a voice in ongoing reforms.**

The United States shifted spending away from institutionalization of older adults in the 1960s in favor of people receiving care in the most community-integrated setting. Key to this shift was government funding for long-term services and supports (LTSS), which help meet the needs of seniors by assisting with activities of daily living such as bathing, dressing, doing laundry, and preparing meals. Services classified as LTSS include institutional care, but here we explore how health centers can improve access to home and community-based services (HCBS), such as adult day programs, meal delivery, home modification, and personal care/homemaker services. In recent years, states have been leading LTSS reforms; the delivery of LTSS is shifting to managed care; and federal programs are working to simplify access to services. There remains an untapped opportunity, however, to build upon these reforms through the engagement of community health centers in connecting seniors to LTSS.

**Health centers are well suited to support LTSS reform**

Community health centers are nonprofit, neighborhood-based clinics that provide comprehensive primary and preventive care regardless of a person's ability to pay. Health centers are in a position to improve the way seniors and residents with disabilities are connected to the services they need, and thus they stand to gain greater attention as a result of the government reforms that are increasingly integrating care into the community. But they are often overlooked, and research on how to improve connections to LTSS via primary care has thus far been minimal.

According to the National Association of Community Health Centers, 49% of health center patients are on Medicaid, a key eligibility factor for most LTSS programs.[1] Health centers serve patients across the lifespan and are equipped to tackle issues of access due to their geographic locations in underserved, low-resource communities that could benefit from increased services. Though they do not typically serve a large population of seniors, health centers could benefit financially from serving this population because seniors are typically enrolled in Medicare, which reimburses at a higher rate than Medicaid alone.

**Some health centers already work to note social determinants and connect patients with LTSS**

One strategy employed by some health centers is hosting adult day services on-site. This type of programming can build community in the clinic. It also reverses the way patients have typically first come to connect with a health center, namely for needed care. When a wider range of services is offered, a senior may come to the clinic for the adult day program, and their medical and home care needs can be identified once trust in the organization has been established.

Other health center efforts to connect seniors to services, while not specifically related to LTSS as such, include establishing relationships with senior centers and providing information on their websites about services such as Meals on Wheels.

Formal research on these practices is scarce, and the emerging picture is patchy. Some health centers may screen for social determinants of health, for example, but not have a formal process for LTSS referrals. The Commission on Long-Term Care's 2013 report to Congress recommended a number of improvement for the provision of LTSS, including some directed at provider agencies. One was for LTSS-related information, such as the identification of family caregivers, to be incorporated into care plans in electronic health records.[2] Having this kind of information, which some health centers could supply, would give providers a more robust understanding of factors impacting a patient's health beyond clinic walls. All these small-scale practices can help improve the LTSS referrals and access available in their communities.

**States move forward with LTSS reform but leave health centers behind**

Medicaid is the largest payer of LTSS services, and states are therefore the primary entities tasked with improving LTSS access and delivery. The trend away from institutionalization is reflected in Medicaid spending ratios: 56.6% of all Medicaid LTSS spending in fiscal year 2016 went for HCBS, with some states reaching levels well above that. Oregon spent 81.2% of its LTSS dollars on home services, and New Mexico, Minnesota, Massachusetts, Arizona, and Vermont were all at 70% or higher.[3]

Vermont and Washington are using 1115 Medicaid waivers to expand HCBS coverage to more people at risk of institutionalization, an effort that also aims to prevent the need for more-costly services in the future.[4] These initiatives, which explored using Medicaid and Medicare data to predict which individuals would need LTSS services, included education outreach about available HCBS and how they are useful to patients.[5] In many cases, health centers could be incorporated in such programs to identify patients with moderate needs who could benefit from HCBS.

**Managed care is creating new ways to connect LTSS to health centers**

Some states are working with Medicaid accountable care organizations (ACOs) to improve the provision of LTSS.[6] Massachusetts is requiring ACOs in MassHealth, its combined Medicaid and Children's Health Insurance Program, to set up formal relationships with certified LTSS community partners. The 2016 amendment to the state's 1115 demonstration requested $1.8 billion over five years in Delivery System Reform Incentive Program funding to support providers in building infrastructure and expanding care coordination capabilities. To receive this funding, providers must adopt one of three defined MassHealth ACO models or be either a behavioral health or LTSS community partner.[7] Reforms such as these are helpful in facilitating partnerships between primary care providers and other service providers. In some cases, states also contract with managed care organizations (MCOs), or health plans, to coordinate care for Medicaid recipients. Although this is typically done through ACOs, MCO contracts could be structured to allow the MCO to embed care coordinators into health center sites. It would be important for the care coordinators to be part of patient care teams to ensure a clear line of communication with medical staff for this approach to be most effective.

As managed care becomes the dominant Medicaid modality, models such as these require a patient to be a member of an ACO or health plan to receive this care coordination.

**Health centers and primary care providers can boost the perception of HCBS as prevention**

The federal reforms that have led community-based care to dominate LTSS have by and large approached HCBS as a response to hospitalization, or as rehabilitation services, rather than as a form of prevention. A federal partnership involving the Administration for Community Living, Centers for Medicare and Medicaid Services (CMS), and Veterans Health Administration has formed to promote the No Wrong Door (NWD) system.[8] The idea is that a person who contacts any organization in an NWD system is connected with the LTSS they need, without having to try to navigate the complex maze of agencies and eligibility requirements – an approach that also helps states use resources more efficiently. NWD currently has legislative and/or gubernatorial support in 33 states.

Healthcare entities currently listed as part of NWD include nursing homes, VA medical centers, and hospitals, but not health centers.[9] Similarly, social services are included, but primary care has been largely left out. This exclusion has kept health centers and primary care providers out of the conversation on LTSS programs and reforms. Primary care is inherently preventive, and health centers provide predominantly primary and preventive care. Greater inclusion by both has the potential to advance the perception of HCBS as a preventive measure, leading to it being used as such. Support by NWD and other federal programs could go a long way to promote this inclusion.

**Health center partnerships facilitate access to HCBS**

Health centers may not be direct entry points in the NWD system, but they are able to build partnerships and educate patients, and thus are far from powerless. One opportunity lies in developing relationships with aging and disability resource centers (ADRCs), which are NWD entry points to the complex LTSS delivery system for older adults and persons with disabilities. Establishing relationships with area agencies on aging (AAAs), which coordinate social services for seniors and are also often participants in NWD systems, can also be effective in supporting the health of seniors. A recent study in *Health Affairs* noted that AAAs that maintained informal partnerships with a wide variety of healthcare entities and other organizations in the community had significantly fewer hospital readmissions than those that did not.[10]

Relationships with both ADRCs and AAAs can also serve to further build the network of resources to connect patients to LTSS in their area. Successful partnerships would require provider and staff education about ADRC and AAA activities as a first step. Patient education, handouts, and word-of-mouth encouragement from physicians would further facilitate access to HCBS through these channels.

**Health centers need to expand their role in ongoing HCBS reforms**

Macro-level federal and state reforms have served as vital steps in the shift away from institutionalization and the growth of community-based supportive services. The benefits seen by health centers, and their ability to play a role, have thus far been minimal, however, and they have largely been discounted in reform efforts. Health centers have the potential to play a vital role in ongoing HCBS reforms, via partnerships, staff training, and medical records entries, and to thereby increase to the efficiency and effectives of connecting residents to LTSS. To achieve this requires a more active role by health centers in the ongoing evolution of these reforms. Governments, for their part, need to shift their concept of HCBS from seeing these services as a response to a problem to recognizing them as a powerful preventive strategy. This shift in itself will likely drive greater inclusion of health centers in LTSS planning and funding.

This document represents a brief summary of the methods being used to connect seniors with HCBS, the role that health centers are playing in these efforts, and the potential that they have to do more. Further research is warranted on how to improve HCBS access and awareness, to identify and refine best practices in connecting older adults and people with disabilities to LTSS.

**Sources**


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