NASUAD
National Association of States
United for Aging and Disabilities

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John R Graham
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Acting Assistant Secretary Graham:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you to share our comments on the draft Department of Health and Human Services (HHS) Strategic Plan for 2018-2022. NASUAD is a nonpartisan association of state government agencies and represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including Medicaid long-term services and supports (LTSS), the Older Americans Act (OAA), and a variety of other health and human services programs. Together with our members, we work to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability and for their caregivers.

In addition to the specific comments on sections of the plan that we discuss below, we have the following general comments on the overall structure of the plan and its underlying goals and objectives:

1) The strategic plan is very high-level. While we recognize that HHS is an extremely large and complex program and that detail on all the agency strategies and programs would result in a prohibitively long document, we believe that there are opportunities for targeted discussion and description of how the agency intends to support its goals and objectives. As it is currently written, the program discussion is overly broad and often the goals don't align directly with the programs cited to provide services that support each objective.
2) The plan is overly focused on clinical and medical interventions. We note that there is a growing recognition across health and human services providers regarding the role that a wide range of social, economic, and interpersonal factors play in the health status of individuals. Though we recognize that there is some discussion of social determinants of health within this document, they are often made in passing and are largely overshadowed by the focus on medical

interventions. We believe that a stronger emphasis should be placed on supporting the health and well-being of participants through a wide range of social supports, including long-term services and supports, in addition to medical interventions.

3) During the discussion of long-term services and supports, some of the core priorities of the Administration for Community Living (ACL) are not reflected. During his confirmation hearing, Assistant Secretary on Aging Lance Robertson outlined four areas that he believed ACL and HHS should prioritize. This includes improving access to information about LTSS; supporting unpaid caregivers; strengthening elder justice; and increasing the business acumen of community-based organizations in the aging and disability networks. Notably, the strategic plan does not include discussion of or references to efforts to improve business acumen or to improve access to information regarding LTSS. We believe that HHS should ensure that the strategic plan aligns with the Assistant Secretary's priorities.
4) LTSS is largely segregated into one single area of the strategic plan, under objective 3.4. We agree that it is important to have a specific objective discussing supports and services for older adults, people with disabilities, and other LTSS programs. However, one of the goals of state agencies is to ensure that LTSS is integrated into the overall strategy for population health and welfare. We believe that there is a need to intertwine LTSS, aging, and disability issues throughout all the strategic plan's goals and objectives.

In addition to the broad comments, we offer the following comments on specific sections and objectives within the strategic plan. We have included numbers in parentheses after each comment, which correspond with the numbered lines within the plan.

- Objective 1.1:
    - The first bullet point under this objective discusses evidence-based programs, but ACL is not listed as an agency with responsibility for implementation. Given its focus on evidence based programming, particularly under the OAA's Title III-D Health Promotion activities, ACL should be noted as an important part of this effort (142).
    - We agree with the focus on ensuring that consumers have adequate information to make meaningful, informed choices. We note that this effort must recognize the importance of the State Health Insurance Assistance Programs (SHIPs) as well as the role of Aging and Disability Resource Centers (ADRCs) and Information and Referral networks. ACL should be recognized as a contributing entity to this objective. Additionally, all future Administration recommended budgets must provide adequate funding for SHIPs and ADRCs to support this initiative (158-172).
    - Streamlined eligibility and enrollment processes are crucial components of aging, disability, and LTSS networks. ACL has been working with states to establish No Wrong Door LTSS eligibility systems, and these initiatives should be recognized and strengthened as part of the HHS strategic plan (178).
- Objective 1.2:
    - We strongly agree with the objective to improve prescribing patterns and reduction of opioid and painkiller utilization, particularly as we note that older adults are a population increasingly impacted by abuse and addiction stemming from painkiller

utilization. We also recommend that this objective should include initiatives and funding for pharmacists, nurses, and other qualified professionals that review prescriptions to identify and ameliorate negative interactions (230).
    - We believe that the adoption of interoperable health information systems should include LTSS and that health information technology should be available for LTSS and social providers in addition to health care providers. The current discussion of this initiative is overly focused on clinical information and does not take into account the wide range of LTSS and social supports that older adults and people with disabilities utilize on a regular basis (257-260).
    - Efforts to disseminate evidence-based programs should also include strategies to address the social determinants of health of populations served (264).
    - We believe that patients should be provided the necessary supports to empower person-centered care, but note that this should include efforts to increase self-determination and person-centered practices in LTSS. LTSS has been a leader in this area, with proven models for self-direction. HHS should leverage and expand upon these successes to support their initiatives under this objective (275).
    - Family engagement is a crucial component of effective supports and services to individuals who receive LTSS and engaging their caregivers. We believe that efforts to strengthen information and referral, options counseling, and the ADRC network should be reflected in the strategies to improve engagement of families (277).
    - We strongly agree that quality reporting should include experience and outcome measures. We recommend that HHS continue to work to develop meaningful measures for LTSS, which include information from participant experience surveys. We note that NASUAD's NCI-AD survey, developed in collaboration with a number of states and HSRI, is a successful model for evaluating the health and social outcomes for older adults and people with physical disabilities across multiple health and human service programs (280).
    - We agree that quality improvement should be a collaborative undertaking that includes health care providers, but we want to stress that HHS should also some of its other core partners, such as states, community-based organizations, long-term services and supports providers, and related entities that may not provide direct clinical care (300).
    - Efforts to expand data collection and promote access should also include LTSS in addition to physical and behavioral health (303).
- Objective 1.3:
    - We agree that HHS should continue to provide information and assistance to consumers. As we noted earlier, this would require SHIP to be fully funded, as well as full promotion and funding of information and referral systems, ADRCs, options counseling, and related programs and supports (339).
    - Access to health care should recognize and include hearing services in addition to the other supports listed. Additionally, our work has identified gaps in coverage and access to oral health services for older adults and people with disabilities that we believe HHS should focus on addressing (387).

- Objective 1.4:
    - ACL not listed as a partner under this initiative, but this objective deals with provider shortages, which are a pressing issue in LTSS and must be addressed. We believe that ACL should be a primary partner in this initiative and objective, and efforts to address provider shortages must include LTSS as a focus area (406).
    - We agree with HHS' models to expand the types of supports and services that various providers can deliver. We believe that HHS should include nurse delegation and scope of practice-related issues in its assessment of successful programs. HHS should also include programs and initiatives that provide supports for family caregivers (442).
- Objective 2.1:
    - Nutrition standards should include flexibility to experiment with different meals and delivery systems in order to promote participation and proper nutrition. State experience indicates that rigid application of standards has led to a reduction in utilization as well as wasted food. We also believe that supports should specifically include expansion of home-delivered meals under the OAA (520).
    - We agree that HHS should continue its successful efforts to reduce tobacco use. We believe that this should include efforts to reduce utilization at all behavioral health facilities (527).
- Objective 2.2:
    - We believe that this initiative should include increased access to vaccines for people with disabilities and older adults (569).
    - We agree with the strategy to support older adults and individuals with disabilities in self-management initiatives. We believe that this should include full funding of chronic disease management programs at the authorized levels within the OAA (623).
- Objective 2.3:
    - Older adults should be included in more places than just the collaboration bullet, given the prevalence of painkillers and other prescription use, which is leading to other forms of addiction (654).
    - We agree with expanding the settings of screening for substance abuse and behavioral health conditions, and recommend that this should be incorporated into settings within the aging and disability networks, including area agencies on aging, centers for independent living, and adult protective services programs, and other related supports and services (668).
- Objective 2.4:
    - All emergency preparedness should have a strategy for older adults and people with disabilities, particularly given mobility issues and special health needs during disasters. We note that drug shortages for older adults and people with disabilities have been a specific problem in the aftermath of the hurricane in Puerto Rico, and that victims of the California wildfires were disproportionately older adults. This, unfortunately, highlights the importance of ensuring that there are strategies for

addressing mobility and health conditions of people with disabilities and older adults within emergency preparedness initiatives (761).

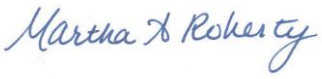
- Objective 3.1:
    - Education and work supports should consider older adults given increasing prevalence of individuals working through older years, re-entering the workforce, etc (889)
    - Work objective should also look to eliminate disincentives across the system, such as Medicaid eligibility criteria that creates disincentives for work (889)
- Objective 3.2:
    - We strongly believe that violence against older adults should be addressed under this objective. As our national State of the States surveys have shown for several years, abuse, neglect, and exploitation has been increasing across the country in the majority of states. We believe that this initiative should recognize the importance of elder justice and protection for individuals with disabilities (925).
    - We believe that the expanded partnerships to reduce violence should include additional federal funding and policy support for adult protective services. We also believe that HHS should recognize and expand upon the elder justice initiative (954).
- Objective 3.3:
    - Initiatives for supporting healthy families must to recognize that many grandparents are raising younger children and include strategies to support these types of nontraditional services. This initiative also should recognize and support families who are caring for their adult children with disabilities (963).
- Objective 3.4:
    - While we recognize and appreciate the importance of this objective, we are concerned that consolidating the majority of initiatives related to LTSS and services for older adults and people with disabilities is detrimental to the integrated services models that states are working to implement across the country (1053).
    - We believe that there should be a section on improved policy collaboration between CMS and ACL in order to ensure that there is a consolidated Federal approach to LTSS. We note that this could also be included within the Operational Goal, perhaps under goal #5.
    - As we stated in the introduction, we believe that this objective should contain clear and defined objectives and strategies that support the priorities articulated by Administrator Robertson:
        - Information and Referral;
        - Elder Abuse Prevention & Adult Protective Services;
        - Supporting Caregivers, which we note is included in line 1109; and
        - Business Acumen.
    - The youth transition goal is somewhat unclear. We believe that this goal is focused on ensuring that there are proper plans in place for kids who are transitioning into adult services and supports, which is important, but the current structure of the goal makes its intent somewhat unclear (1086).

- We believe that HHS should include efforts to expand respite and adult day services as part of the overall strategy to support caregivers (1110).

We recognize that the strategic plan was written in a manner that is intentionally high-level, and that each objective contains illustrative examples of activities which are not intended to be all-encompassing. However, we believe that these comments are necessary to ensure that LTSS are provided in an integrated, person-centered manner. We also believe that the needs of older adults and people with disabilities should be recognized across the broad range of services and supports and objectives that HHS administers. Inclusion of these perspectives throughout the HHS strategic plan will help strengthen the ability of the agency to achieve its mission.

Thank you for your efforts to improve the strategic focus of the agency. If you have any questions about our comments, please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,



Martha A. Roherty
Executive Director
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