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Community-based prototypes play an integral role in effecting lasting healthcare change

By **Robert J. Schreiber**

Our current healthcare system for older adults and individuals with disabilities was built to provide acute medical care, but does not routinely include wellness approaches to prevent or manage chronic disease. In addition, it has not included integrating social support systems provided by community-based organizations in any replicable or sustainable manner. Paul Batalden, senior fellow and founding chair of the Institute for Healthcare Improvement's Board of Directors, coined a corollary to onetime Proctor & Gamble's European Training & Development Manager Arthur Jones' observation that "all organizations are perfectly designed to get the results they get," countering with "every system is perfectly designed to get the results it gets" (*http://goo.gl/RIoVjr*).

However, this reactive system of care is now being transformed by value-based payments, a shift that is profoundly affecting healthcare providers, institutions and payers. The impact on community-based organizations (CBO) will be pronounced. CBOs will need to adapt their approach to a value-based business model to maintain and–or improve their standing with healthcare payers and providers. New prototypes need to be developed, tested and rapidly replicated to meet this challenge. As Anne Montgomery of the Altarum Institute wrote in January 2016, the aging services network is "hanging in the balance" (*https://goo.gl/0qir5C*).

The Expanded Chronic Care Model and a Prototype

A model exists that demonstrates one approach to improve population health through healthcare system transformation. Called the Expanded Chronic Care Model (*http://goo.gl/ifbrp2*), it is adapted from the evidence-based Chronic Care Model (CCM; *http://goo.gl/aKCXVK*), which outlines a medical approach for chronic disease management. The Expanded Chronic Care Model (see Barr et al. in *Hospital Quarterly*, 2003; *http://goo.gl/96Byal*) integrates the CCM, while promoting population health. It shows how communities, CBOs and the healthcare system can engage collaboratively in decision support, self-management and redesign of information systems and delivery systems. These activities are co-located in the healthcare system and in the community to better integrate chronic medical treatment with health promotion and improve population health.

As a practicing geriatrician, I have been collaborating and partnering with CBOs for more than 30 years. This experience has culminated in the creation of a community-based prototype

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model based on the Expanded Chronic Care Model, the Massachusetts Healthy Living Center of Excellence (HLCE).

Led by Elder Services of the Merrimack Valley, a CBO, which has partnered with Hebrew SeniorLife, a medical care provider, and an Advisory Committee representing community stakeholders, we are working to redefine the healthcare delivery system with the goal of achieving better health outcomes and better healthcare—both at sustainable costs. This collaborative partnership involving both motivated older adults and individuals with disability, their medical providers and community-based services is the most effective model for managing the healthcare needs of an ever-growing aging population, according to Coleman et al. in a 2014 article in *Family Practice Management* (*http://goo.gl/6wYs06*).

We at HLCE strive, as do most CBOs, to promote the independence of older adults by empowering them and their families to take more active roles in their care. We do this by disseminating evidence-based self-management statewide (including the Stanford Chronic Disease Self-Management Program; *http://goo.gl/tyVBp4*) through a network of more than 90 regional collaborating community providers.

Through exposure to these programs and their outcomes, healthcare providers understand the important roles CBOs have in supporting older adults and those with disabilities. New business agreements are coming about, as health plans, hospitals and healthcare providers partner with CBOs that have been able to state their value proposition involving home- and community-based long-term support services, care coordination, care transitions and evidence-based programs. This "outside in" approach, focused on delivering value for partners (see the July–August 2016 issue of **Aging Today**, *www.asaging.org/blog/matter-mindset-cbos-must-master-outside-in-thinking*), can transform care for older adults with complex medical needs and individuals with disabilities—a necessary component of improving population health.

Next Steps

So how are CBOs to proceed? CBOs are well-positioned to improve on their present models, as well as develop new ones, to help transform healthcare as we know it. Two examples include the following: Area Agencies on Aging are meeting the needs of clients in a conflict-free manner, thus helping older adults remain in their homes; and the Alzheimer's Association provides vital information on what can be done proactively to help individuals, families and healthcare providers of elders with Alzheimer's and other dementias. These and other CBOs recognize the central role of both the patient and caregiver and ensure their voices are heard and their needs are met, based on their stated values and goals.

In late summer, the Hartford Change Agents Patient-Centered Medical Home (PCMH) Network disseminated a white paper called "Patient-Centered Medical Homes and the Care of Older Adults" (*https://goo.gl/fCQDGB*), which highlights the many ways CBOs can play an essential role in comprehensive care coordination and person-directed care. This paper highlights the important role CBOs have in helping the PCMH deliver care to older adults with and without complex medical needs and-or disabilities.

One transitional step many CBOs have taken is to apply existing, proven business models that can add value and financial return through the use of evidence-based programs for chronic disease self management, fall prevention, exercise, mental health, nutrition and care transitions. Ever-increasing numbers of CBOs are piloting such programs, investing in infrastructure and being provided with technical assistance by accessing learning collaboratives, such as the Linkage Lab Initiative sponsored by The SCAN Foundation.

There is significant expectation from CBOs and researchers that these programs may become a Medicare benefit in the near future if value can be demonstrated in ongoing studies. The U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services

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on March 23, 2016, announced that for the first time there will be Medicare reimbursement for a community evidence-based program (*http://goo.gl/G7e0WA*). Beginning in January 2018, the Diabetes Prevention Program will be covered by Medicare, and will expand Medicare providers into the community, partnering with organizations like the YMCA and other CBOs in health promotion and prevention. The program includes dietary coaching, lifestyle intervention and moderate physical activity, all aimed at preventing onset of diabetes in pre-diabetic individuals. There will be 16 intensive core sessions in a group-based, classroom-style setting, followed by less intensive monthly meetings.

The U.S. healthcare system cannot improve health outcomes unless health promotion and wellness are integrated into medical care. CBOs must play an important role in this health promotion and wellness approach. This new reality will require developing new collaborative networks with the reach and business acumen to meet community needs for population health. The challenge is great and failure is not an option. Older adults, those with and without disabilities, want to live with dignity and independence in their communities. And the cost of this proposition needs to be sustainable for their families. As Joanne Lynn has observed (*JAMA*, 2014; *http://goo.gl/tO7Pjp*), their future and that of our larger society hang in the balance. ■

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