Patient-Centered Medical Homes and Community-Based Organizations: Partnerships to Improve Population Health

Innovative Programs for Integrated Care

Rob Schreiber MD, AGSF, CMD
Medical Director, Evidence-Based Programs at Hebrew SeniorLife
Medical Director, Healthy Living Center of Excellence

Nora Super
Chief, Programs and Services, National Association of Area Agencies on Aging, Washington, DC

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

John A. Hartford Change AGEnts Initiative

Patient Centered Medical Home Network

Paper Highlights

- Compelling stories of how PCMHs have transformed outcomes for older adults;
- How practices can improve outcomes by implementing evidence-based models of care;
- How community-based organizations can play an integral role in helping PCMHs maintain older adults' independence and quality of life;
- Actions PCMHs can take to enhance primary care delivery;
- How advanced PCMHs can benefit under the Medicare Access and CHIP Reauthorization Act (MACRA) and employ Advanced Alternative Payment Models (APMs) without putting themselves at risk of financial loss.
- The challenges & opportunities PCMHs face in five areas: comprehensive care, whole-person care, patient empowerment & support, care coordination & communication, and ready access to care; and
- Links to resources to aid PCMHs in addressing workforce issues, partnering with community-based organizations, accessing clinical assessment tools, ensuring patient safety, and more.

Change AGEnts - PCMH Network

Mission

- Transform PCMHs to improve the care of older adults and their caregivers.
- Advocate for and promote thoughtful insertion of geriatrics into the PCMH model.
- Identify ways to improve the skills of PCMH clinicians who may not have formal geriatric training, at both the patient and population levels.

Members

- Robert Schreiber, MD, AGSF, CMD
- David Dorr, MD, MS
- Christine Fordyce, MD
- Robyn Golden, MA, LCSW
- Molly Mettler, MSW
- Toni Miles, MD, PhD
- Aanand Naik, MD
- Harry S. Strothers III, MD, MMM,
- Tasha Woodall, PharmD, CGP, CPP
- (previous) Colleen Casey, PhD

Paper Highlights

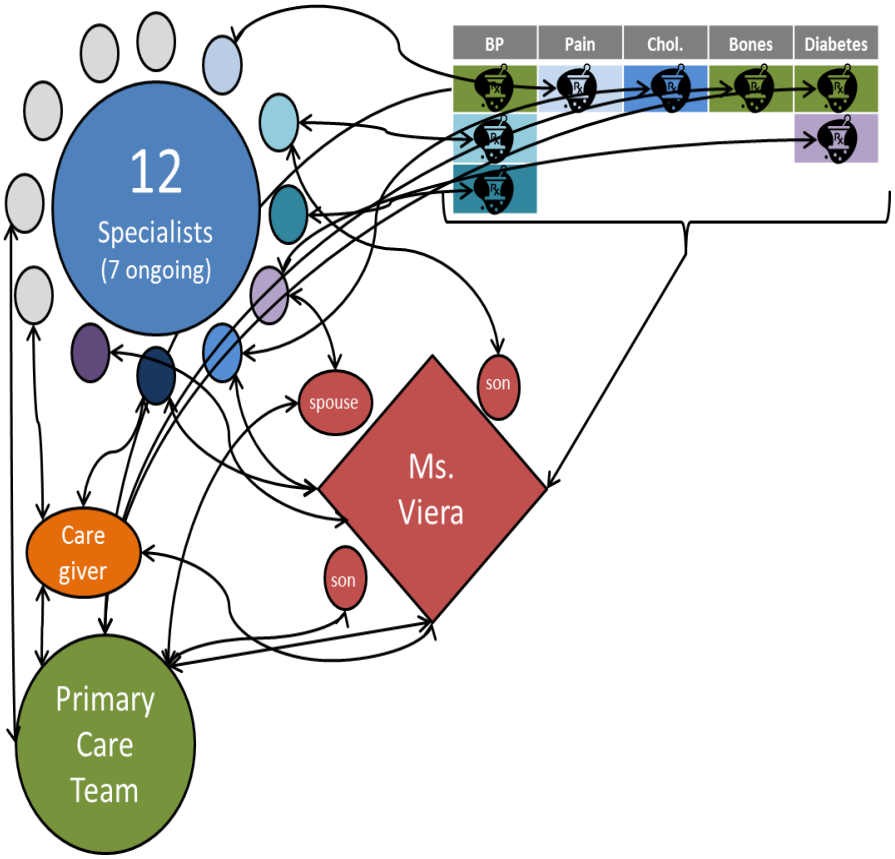
- The integral role of community-based organizations in helping PCMHs maintain older adults' independence and quality of life
- How practices can improve outcomes by implementing evidence-based models of care including self-management programs, care transitions programs
- Links to resources in addressing workforce issues, partnering with community-based organizations, accessing clinical assessment tools, ensuring patient safety, and more

Paper Highlights

- How advanced PCMHs can benefit under the MACRA and employ APMs without risking financial loss
- Challenges & opportunities PCMHs face in five areas: comprehensive care, whole-person care, patient empowerment & support, care coordination & communication, and ready access to care

Why a CBO Focus on Primary Care?

- Majority of older adults receive care from primary care teams *without formal training in the needs of older adults;*
- Historically, the bulk of high need patients in primary care practices are older;
- Primary care is increasingly the focus of health reform to reduce risk, improve outcomes, and reduce costs (in programs mostly known as *Patient-Centered Medical Homes* or *Advanced Primary Care)*



Why a Paper about older adults focused on PCMHs?

"If PCMHs are going to succeed in their goals of improving patient outcomes and lowering costs, they must address the unique needs of older adults."

From *Patient-Centered Medical Homes and the Care of Older Adults: How comprehensive care coordination, community connections, and person-directed care can make a difference* by The John A. Hartford Foundation PCMH Change AGEnts Network.

HARTFORD Change AGEnts

THE JOHN A. HARTFORD FOUNDATION 1929

Environmental Scan

Money in in the Health System

- Be bilingual-"learn the language" of health care.
- Understand "what keeps them up at night" to create interventions to help them "solve their problems".

The U.S. Healthcare Reality: Multiple Chronic Conditions Challenge

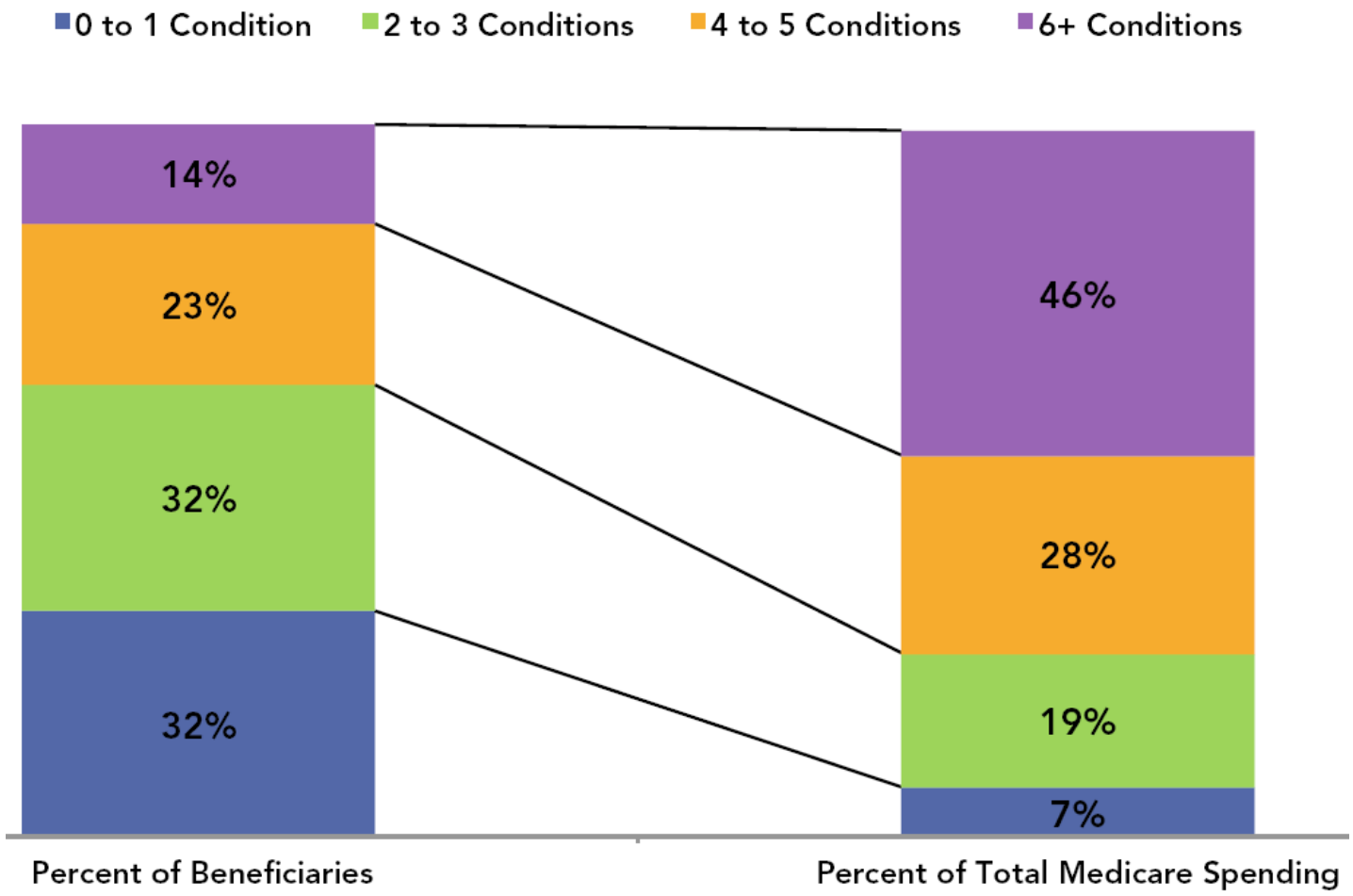
Prevalence

- 26% of adults have MCC
- 66% of fee-for-service Medicare beneficiaries have MCC
- 67% of Medicaid beneficiaries w/ disabilities have 3 or more conditions

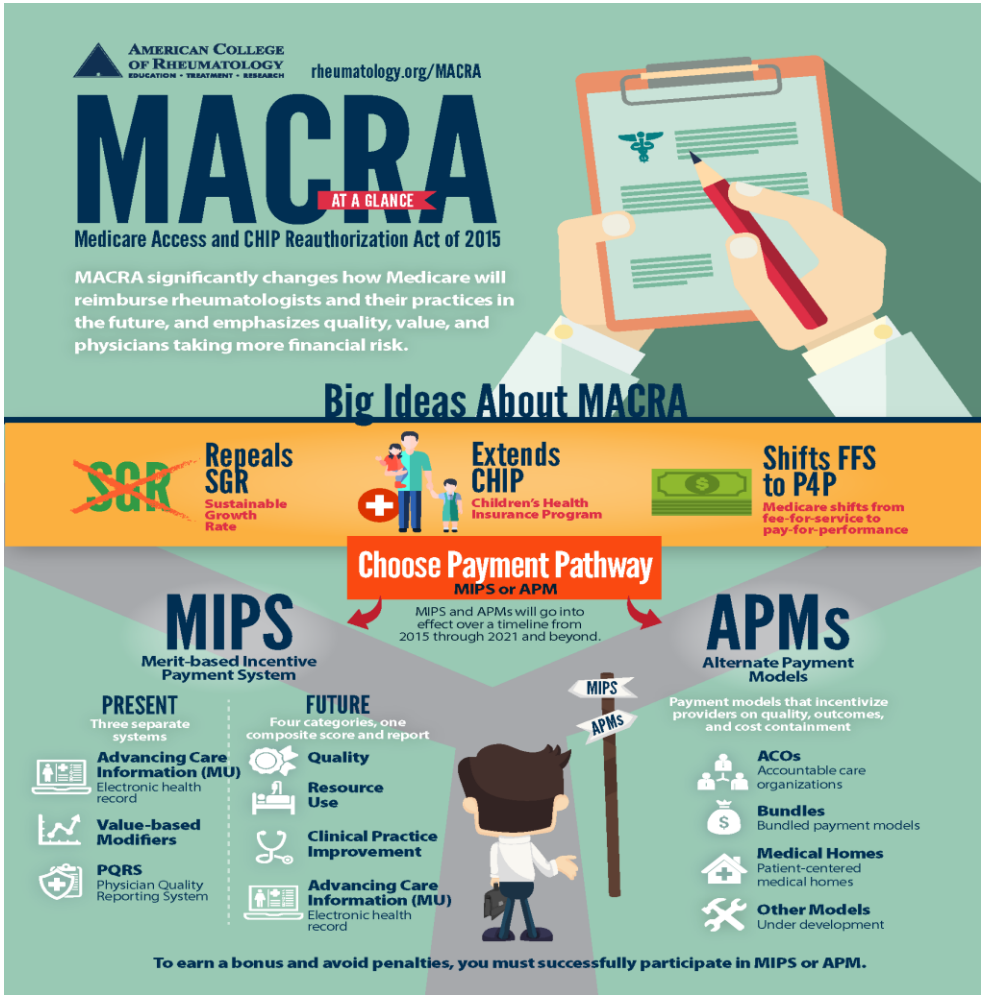
.

Sources: Anderson, RWJF, 2010; Kronick, CHCS, 2009; Lee, JGIM, 2007; Machlin, AHRQ, 2011; Vogeli, JGIM, 2007; Ward, PCD, 2013; Warshaw, Generation, 2006; Wolff , Arch Intern Med, 2002; http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Maps_Charts.html; http://www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

Proportion of Medicare Fee for Service Spending



Healthcare Transformation has Begun

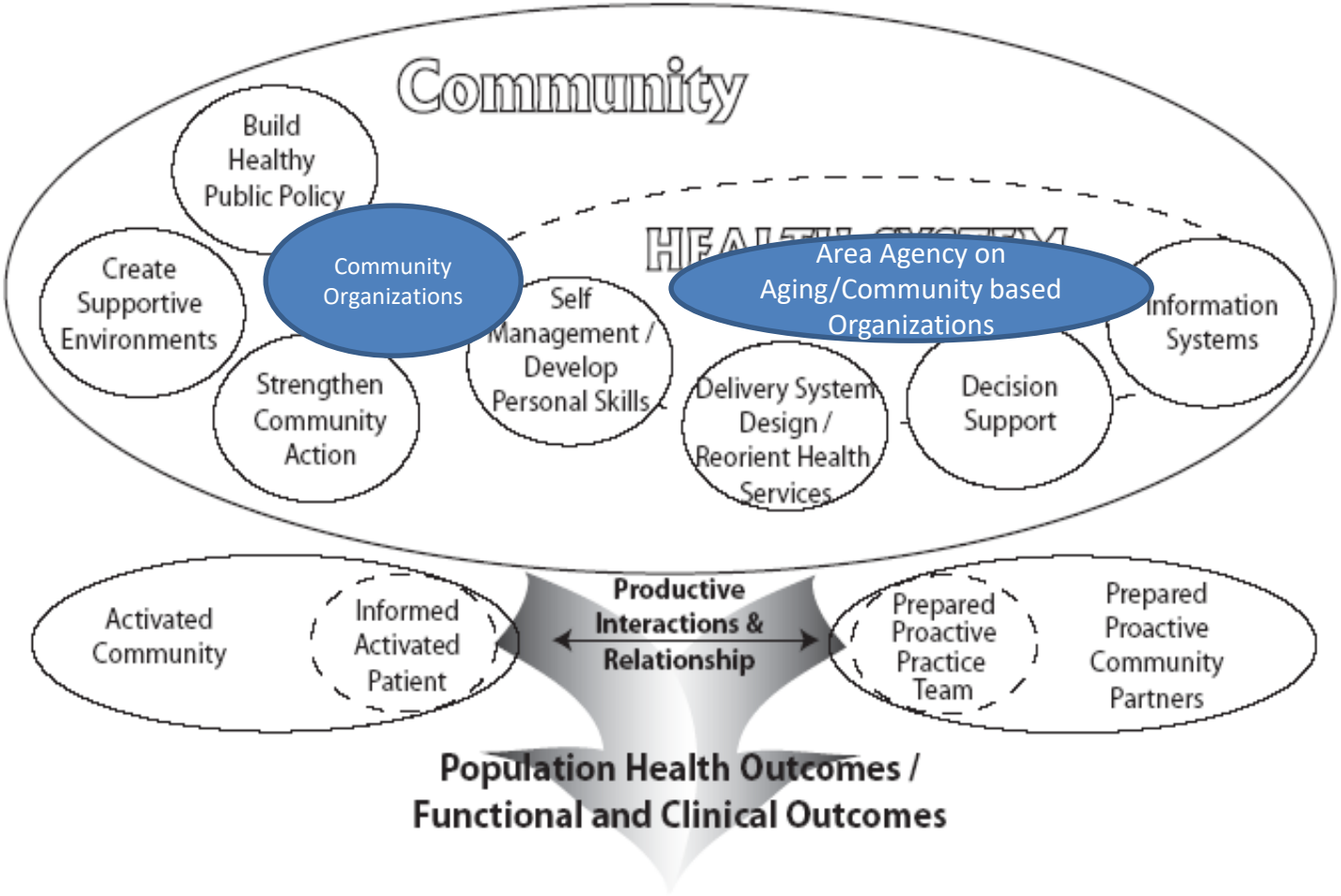


Comprehensive Primary Care (CPC) and CPC+

- Risk adjusted, non visit-based payment
- Designed to augment staffing and training, according to specific needs of patient population
- Paid by all payer partners (support amount will vary by payer)
- No beneficiary cost sharing
- Risk tiers relative to regional population

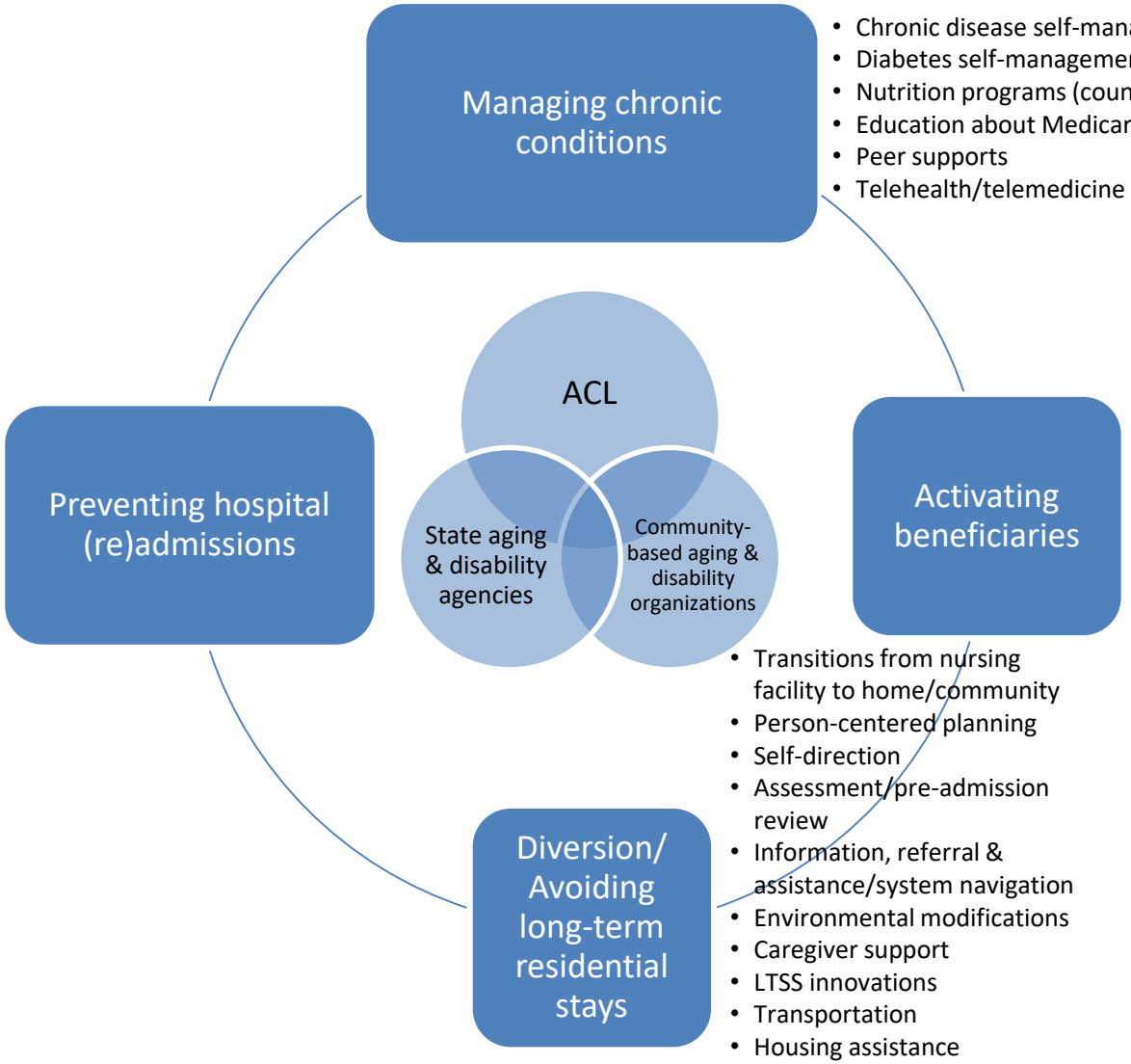
Complex Tier: $100
Top 10% of risk or dementia diagnosis

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION

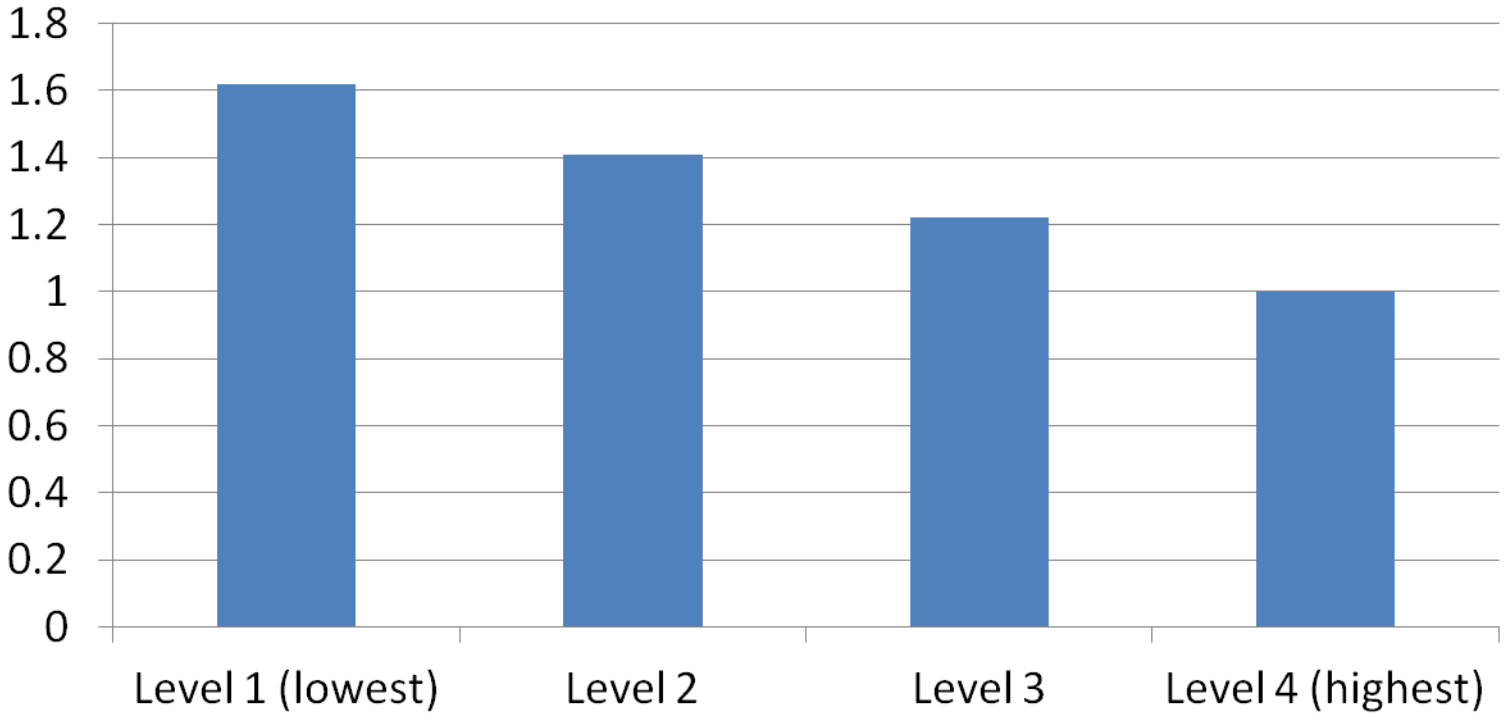


The Expanded Chronic Care Model, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

The Critical Role of Community-Based Organization In Delivery System Reform



Odds of Hospital Use for Ambulatory Care-Sensitive Conditions after Year One, by Patient Activation Level

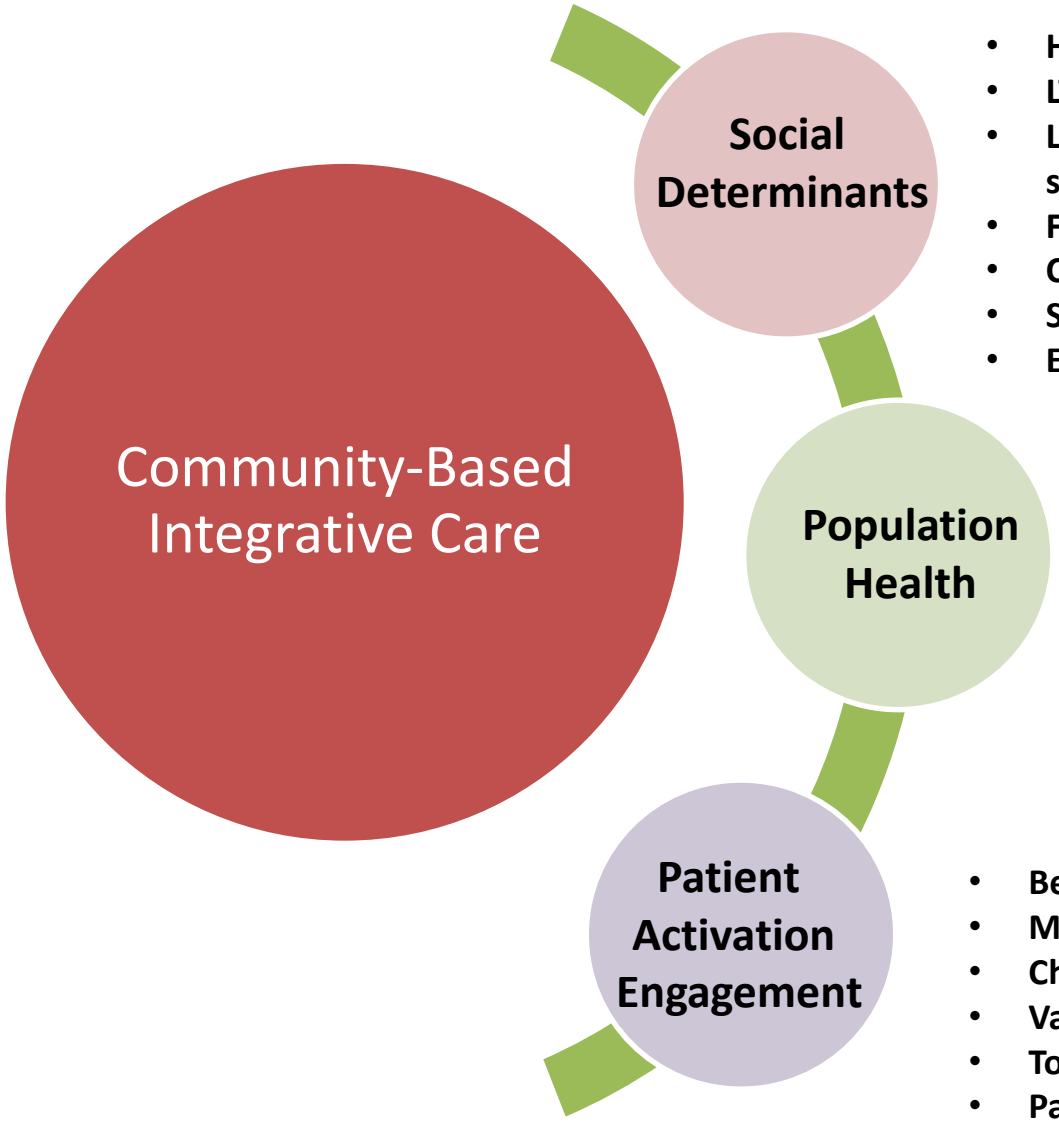


Lowest Patient Activation Level highest

Judy Hibbard et al, Health Services Research On-Line August 23, 2016, https://www.ncbi.nlm.nih.gov/pubmed/27546032

What is the Bridge to "Community-Based Integrative Care"?

- Long-term service supports
- Care transitions
- Chronic disease management
- Cognitive Screening and Referals
- Caregiver support
- End Of Life Planning
- Behavioral Health Supports
- Activated, Empowered and Engaged Patients



- Housing, Transportation and Living environment
- LTSS Supports-Care Transitions
- Level of independence, caregiver and/or social supports
- Financial stability and access to benefits
- Cultural and social barriers to care
- Social Inclusion
- Education

- Access to Health Care
- Health Disparities
- End of Life Planning
- Medication management and reconciliation
- Compliance and adherence to care and self-management
- Patient Centered Care coordination, navigation, assessment

- Behavioral Health Supports
- Motivational Interviewing
- Chronic Disease Management Programs
- Values, preferences, and advanced directives
- Tool to manage health and chronic conditions
- Patient and Caregiver Activation and engagement

Value Proposition for Community-Based Integrative Care

- Conflict Free
- Patient activation

- Outcomes
  - Independence
  - "Days at home"
  - Admissions/1000
  - Functional Measures
  - Advance Directives
  - Falls in community
  - Depression

Know your value

- Cost Avoidance
- Improved activation
- Improved satisfaction

http://www.n4a.org/Files/ASA%20article_v37n4_Tabbush_July-August2016.pdf

AgingToday
the bimonthly newspaper of the American Society on Aging
ISSN: 1067-8379 Page 1 JULY–AUGUST 2016
www.asaging.org volume xxxvii number 4

A matter of mindset: CBOs must master "outside-in" thinking to partner up and deliver quality, cost-efficient care

By **Victor Tabbush**

Recent healthcare policy and payment reforms, such as Medicare's Bundled Payments for Care Improvement (BPCI) initiative, the Hospital Readmissions Reduction Program and the Value-Based Purchasing Program, among others, share a common feature: each reform incentivizes financial and performance accountability on the part of medical providers.

Home- and community-based service providers (CBO) are well-positioned to partner with the medical care sector in these integration efforts. In this new payment environment, CBOs can reduce medical costs and improve health outcomes for potential clients and partners (hospitals, post-acute care providers, provider networks and insurers). Success in forming and implementing these partnerships requires CBOs to adopt an outside-in business mindset.

The Business Mindset: Adopting An Outside-In Orientation

To be an attractive partner to the medical sector, the CBO must become an "outside-in" organization, adopting an external orientation in its thinking and actions. The outside-in approach is driven by the belief that creating value for the partner is key to its success.

The "inside-out" approach, in contrast, is driven by the belief that the organization's strengths are the foundation for a sustainable future. If organizations intend to be successful in marketing their services to the medical sector, they will need to shed the inside-out mindset. This prescription stems from recent work The SCAN Foundation has undertaken to build the business acumen of a dozen CBOs. The four symptoms of an "inside-outside" organization are described below.

1. Using terms that the organization itself understands, but are unfamiliar to the potential partner.

If CBOs are to be invited by medical partners to integrate service delivery, they first must avoid terms that, while standard in the LTSS lexicon, may be poorly understood and confusing to the medical sector partner. Acronyms used mainly within the LTSS sector, such as home- and community-based services (HCBS), community-based adult services (CBAS) and multipurpose senior service program (MSSP) may need to be avoided. Potential partners are not going to invest in learning the CBO language; theirs must be learned and spoken by the CBO. CBOs must

What does your organization do as well or Better than anyone else in your area?

Example: We…

- serve our clients **for life**, not episode focused.
- have a **holistic** approach to support individuals in their homes.
- serve individuals **across all care settings.**
- are the **eyes and ears** of medical professionals in the home.
- provide **one door** to many services to support individuals in their homes.
- are the **best value** to improve the health of your community/patients.
- have served your community/patients for **30+ years** and continue to do so today.
- Not Insurance Driven
- "Mission driven BUT Data Informed"

How can you Develop an "Adding Value" Strategy?

- Align your work with the priorities, and fiscal imperatives of Integrated Care Organizations and the other payers in the health care system such as hospitals and emerging ACOs.

- Understand the fiscal incentives driving those organizations – capitation, pay-for-performance, financial penalties for avoidable admissions.

- Redefine – and, if necessary, restyle – your products and services to support the payors' needs. Why do they need you?

- "Value Added" areas can include:
  - Prevention & chronic disease management
  - Patient activation and education
  - Reduced unnecessary utilization of health care
  - Improved access to care
  - Reduced incidence of avoidable hospitalizations
  - Improved overall patient experience and satisfaction

Integrated in Health Care Goals

- Expansion of the “Care Team” to include the patient’s home and community-based networks
- Improve coordination of care and provide appropriate nonmedical interventions to patients with difficulties, such as socioeconomic, physical, functional, and behavioral health issues
- Effective communication for timely and efficient referrals, hand offs, and “closing the loop”
- Patient centered care plans with realistic goals and resources for implementation
- Measurement for required matrix (Tobacco, BMI, Fall Risk, Advanced Directive, Vaccinations)

Five Health Related Values Domains

- Functioning
- Health
- Connection
- Life Enjoyment
- Engagement-Sense of Purpose

Integration in Action: The Healthy Living Center of Excellence

Vision: Transform the healthcare delivery system. Medical systems, community- based social services, and older adult will collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

the healthy living Center of Excellence

Key Features:

* Statewide Provider network of diverse community based organizations
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, fidelity, & quality assurance
* Multi-program, multi-venue, multicultural across the lifespan approach
* Centralized entity for contracting with statewide payors
* Diversification of funding for sustainability
*EBP integration in medical home, ACO and other shared settings

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Massachusetts by the Numbers

- **90+** member CBO provider network
- **7** regional collaboratives
- **600+** program leaders
- **14** evidence-based programs
- **16,000+** participants since 7/2013
- **20,000+** older adults since 2008

HLCE website traffic

- **Over 1,000,000** annually
- **2,600** visits per month
- **1,300** unique visitors per month

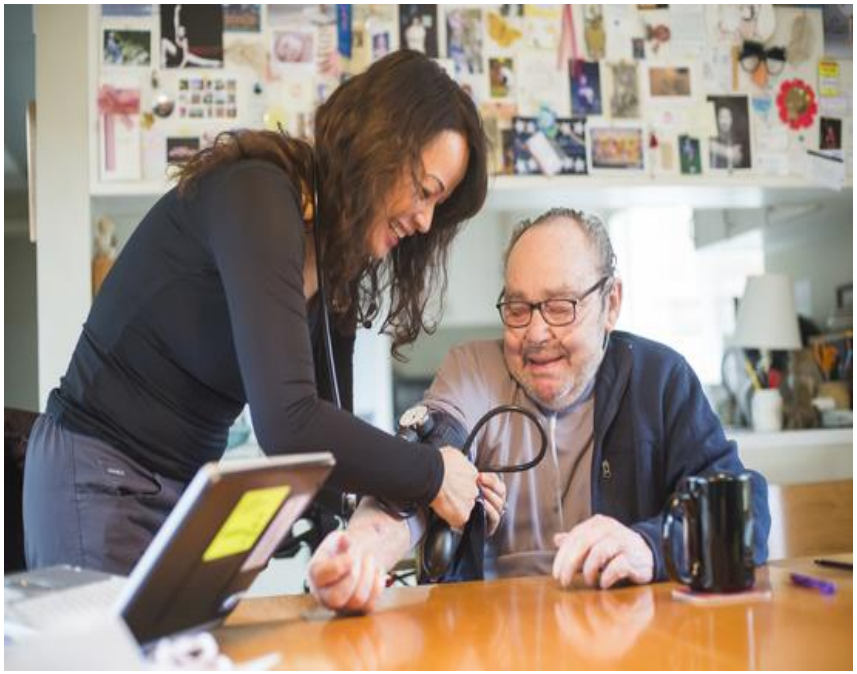
www.healthyliving4me.org

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

the healthy living Center of Excellence

Stories of Use by Stakeholders

Community-Based Organizations Working with Federally Qualified Health Centers



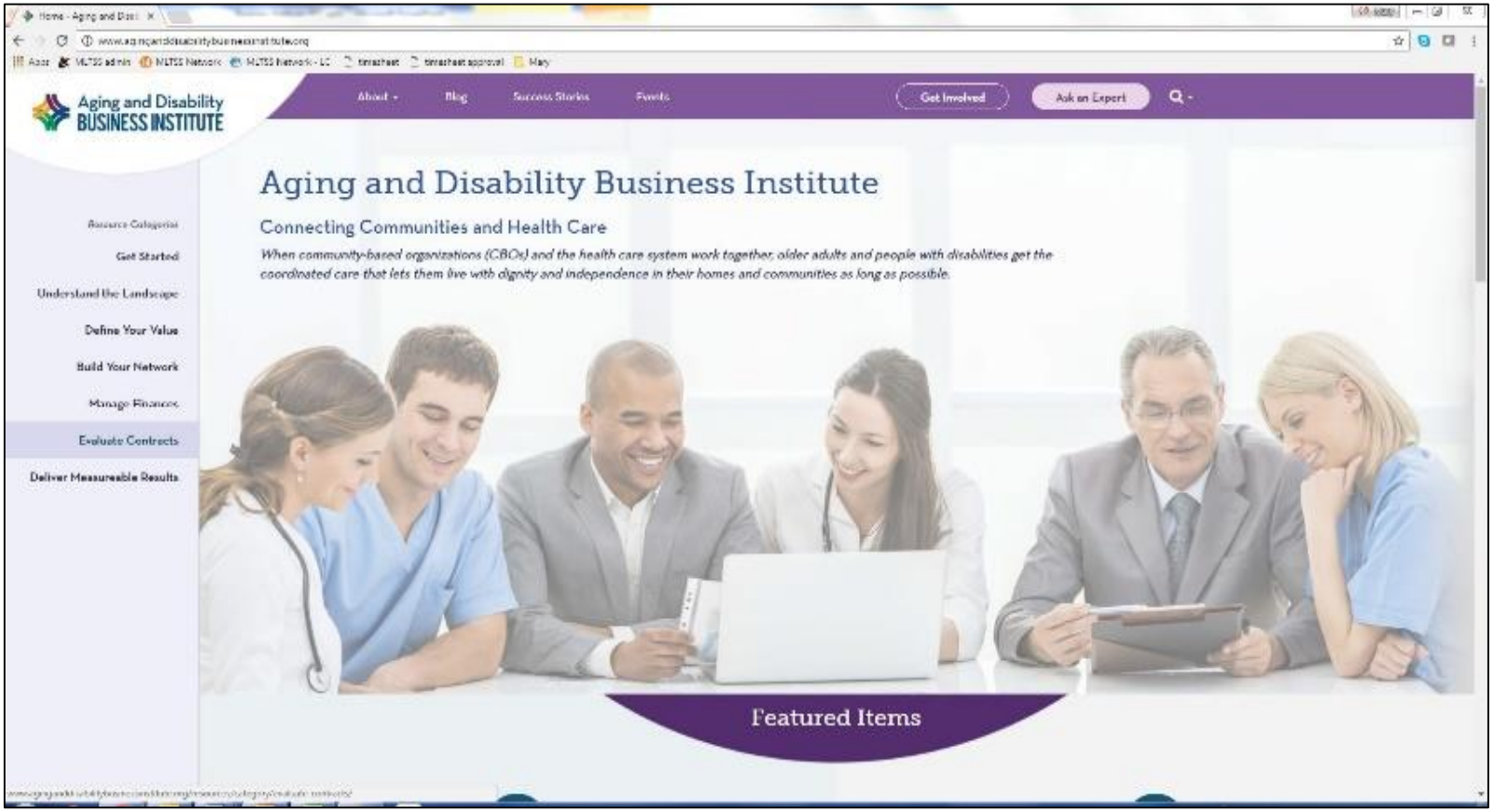
Technical assistance: The "Business Institute"

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

aginganddisabilitybusinessinstitute.org

Aging and Disability BUSINESS INSTITUTE

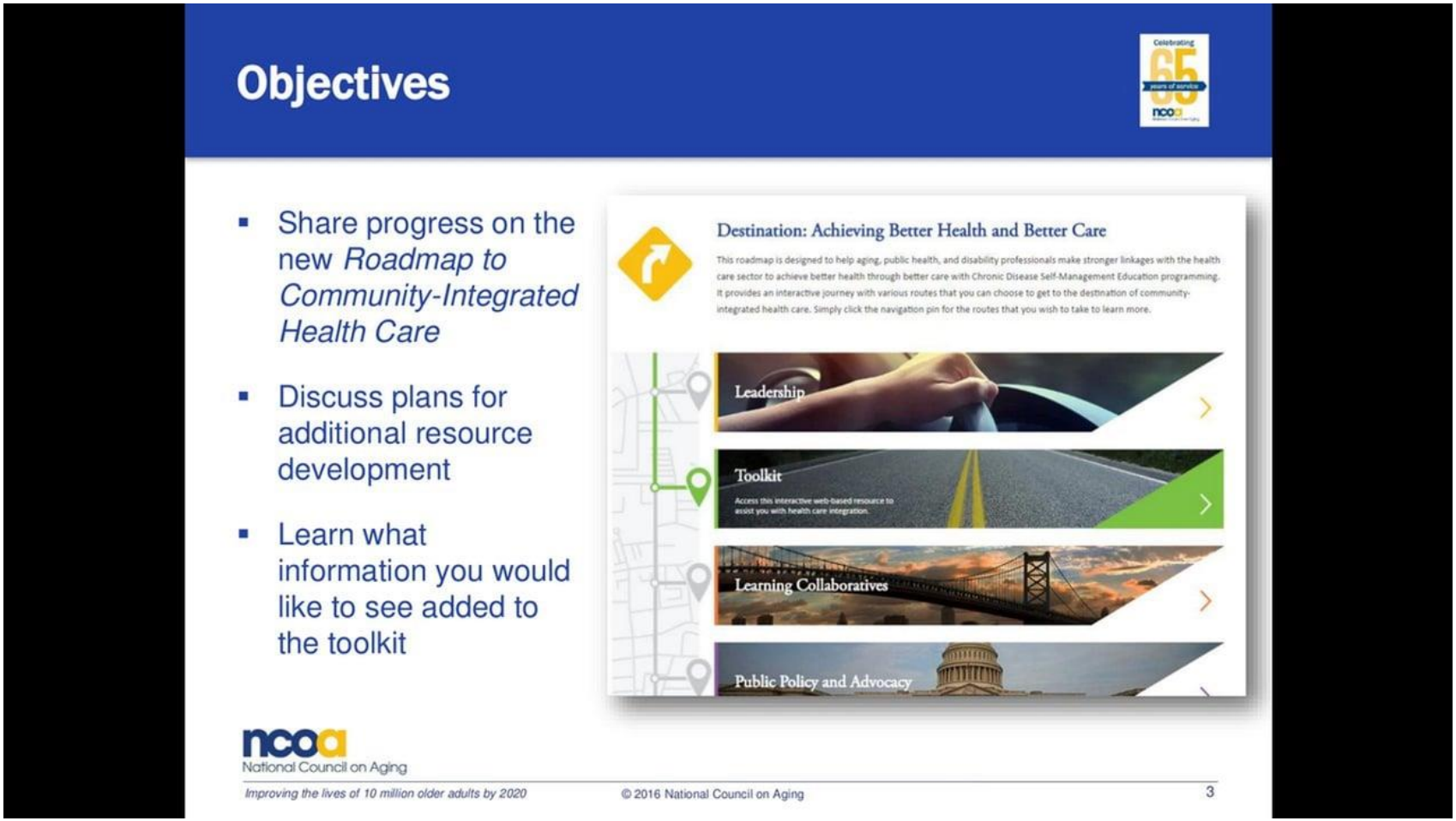
aginganddisabilitybusinessinstitute.org



Aging and Disability
BUSINESS INSTITUTE

NCOA Roadmap to Community-Integrated Healthcare

https://www.ncoa.org/center-for-healthy-aging/roadmap



Get the paper:
bit.ly/2cjVpG8

******

Join the conversation on Twitter:
#PCMH_Roadmap

Questions