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

_Innovative Programs for Integrated Care_

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Patient-Centered Medical Homes and the Care of Older Adults

How comprehensive care coordination, community connections, and person-directed care can make a difference

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**

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- David Dorr, MD, MS
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- 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.
Environmental Scan
Money 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

Proportion of Medicare Fee for Service Spending

- 14% of beneficiaries, 46% of total Medicare spending
- 23% of beneficiaries, 28% of total Medicare spending
- 32% of beneficiaries, 19% of total Medicare spending
- 32% of beneficiaries, 7% of total Medicare spending
Healthcare Transformation has Begun

MACRA
Medicare Access and CHIP Reauthorization Act of 2015

MACRA significantly changes how Medicare will reimburse rheumatologists and their practices in the future, and emphasizes quality, value, and physicians taking more financial risk.

Big Ideas About MACRA

**Repeals SGR**
Sustainable Growth Rate

**Extends CHIP**
Children’s Health Insurance Program

**Shifts FFS to P4P**
Medicare shifts from fee-for-service to pay-for-performance

Choose Payment Pathway
MIPS or APM

- **MIPS**
  - Merit-based Incentive Payment System
  - Present: Three separate systems
    - Advancing Care Information (MU)
      - Electronic health record
    - Value-based Modifiers
    - PQRS
      - Physician Quality Reporting System
  - Future: Four domains, one composite score and report
    - Quality
      - Resource Use
    - Clinical Practice Improvement
      - Advancing Care Information (MU)
        - Electronic health record

- **APMs**
  - Alternate Payment Models
  - Payment models that incentivize providers on quality, outcomes, and cost containment
    - ACOs
      - Accountable care organizations
    - Bundles
      - Bundled payment models
    - Medical Homes
      - Patient-centered medical homes
    - Other Models
      - Under development

To earn a bonus and avoid penalties, you must successfully participate in MIPS or APM.
Comprehensive Primary Care (CPC) and CPC+

Track 1: Four Risk Tiers (Average $15)
- 1st risk quartile: $6
- 2nd risk quartile: $8
- 3rd risk quartile: $16
- 4th risk quartile: $30

Track 2: Five Risk Tiers (Average $28)
- 1st risk quartile: $9
- 2nd risk quartile: $11
- 3rd risk quartile: $19
- 4th risk quartile: $33
- 5th risk quartile: (optional)

- 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, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).
The Critical Role of Community-Based Organization In Delivery System Reform

Managing chronic conditions

- Chronic disease self-management
- Diabetes self-management
- Nutrition programs (counseling & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

Preventing hospital (re)admissions

- Evidence-based care transitions
- Care coordination
- Information, referral & assistance/system navigation
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Nutrition programs (counseling & meal provision)
- Caregiver support
- Environmental modifications
- Housing assistance
- Personal assistance

State aging & disability agencies

Community-based aging & disability organizations

Activating beneficiaries

- Transitions from nursing facility to home/community
- Person-centered planning
- Self-direction
- Assessment/pre-admission review
- Information, referral & assistance/system navigation
- Environmental modifications
- Caregiver support
- LTSS innovations
- Transportation
- Housing assistance
- Personal assistance

Diversion/ Avoiding long-term residential stays

- Evidence-based care transitions
- Person-centered planning
- Self-direction
- Chronic disease self-management
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
Odds of Hospital Use for Ambulatory Care-Sensitive Conditions after Year One, by Patient Activation Level

What is the Bridge to “Community-Based Integrative Care”? 

- Long-term Service Supports
- Care Transitions
- Chronic Disease Management
- Cognitive Screening and Referrals
- Caregiver Support
- End of Life Planning
- Behavioral Health Supports
- Activated, Empowered and Engaged Patients
Community-Based Integrative Care

Social Determinants
- 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

Population Health
- 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

Patient Activation Engagement
- 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
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, handoffs, 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.

**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
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
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

Connecting Communities and Health Care

When community-based organizations (CBOs) and the health care system work together, older adults and people with disabilities get the coordinated care that lets them live with dignity and independence in their homes and communities as long as possible.

Featured Items
NCOA Roadmap to Community-Integrated Healthcare

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

Objectives

- Share progress on the new Roadmap to Community-Integrated Health Care
- Discuss plans for additional resource development
- Learn what information you would like to see added to the toolkit
Get the paper: bit.ly/2cjVpG8

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Join the conversation on Twitter: #PCMH_Roadmap

Patient-Centered Medical Homes and the Care of Older Adults
How comprehensive care coordination, community connections, and person-directed care can make a difference
Questions