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A Primer on Managed Care: Multiple Chronic Conditions

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A Primer on Managed Care: Multiple Chronic Conditions

chronic conditions, social determinants, and Medicare Advantage

supporting Medicare Advantage clients in the community

highlighting innovations in dementia care, in the community

Managing Chronic Disease in an Evolving Healthcare Environment

By Erin Westphal

Community-based organizations increasingly are addressing social determinants of health, and preventing more expensive medical interventions.

Over the past 100 years, great advances have been made in medicine. These have resulted in increased human longevity, however, people are living longer with chronic conditions, as shown in Figure 1 (see page 4). A chronic condition can be a physical condition, such as chronic obstructive pulmonary disease (COPD), or a mental health condition, such as Alzheimer's disease or other dementias. These conditions persist for more than one year and result in functional limitations.

Heart disease, cancer, stroke, COPD, and diabetes account for more than two-thirds of deaths and 75 percent, or $1.5 trillion, of healthcare spending (Wullianallur and Raghupathi, 2018). The systems providing care and payment policies have not kept pace with these medical advancements.

Medicare, the nation's largest payer for healthcare, provides coverage to nearly 90 million people. Twenty percent of those people are dually eligible, meaning they also have Medicaid, the insurance for low-income individuals (Rudowitz and Garfield, 2018). Fourteen percent of these beneficiaries have six or more chronic conditions, and 55 percent have between two and five (Better Medicare Alliance, 2017). When people have both functional limitations and chronic conditions, their use of healthcare services and the attendant costs increase drastically. A person who needs help with one or more activities of daily living costs twice as much to the Medicare program as does someone with no functional limitations. Figure 2 (see page 4) illustrates this point (Tumlinson and Johnson, 2018).

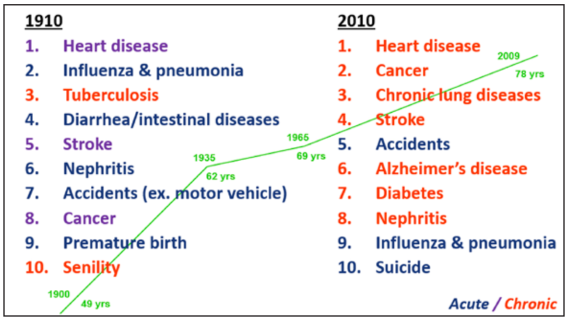
The CHRONIC Care Act advances integrated, person-centered care for Medicare beneficiaries and dual eligibles.

The Changing Landscape of Care Provision and Reimbursement

In response to the older adult population living longer with chronic conditions and functional

➔ABSTRACT Now, more than ever before, people are living longer with chronic conditions. More than half of Medicare beneficiaries have two to five chronic conditions. In addition to managing their clinical conditions, many are dealing with social determinants of health. Beginning with the advent of the Affordable Care Act, the healthcare sector has seen a shift to value-based care and an increased focus on outcomes. As it has taken on more risk, the healthcare sector has recognized it must address the patient as a whole person and not merely focus on clinical conditions. | **key words:** *chronic conditions, social determinants of health, community-based organizations*

Figure 1. Life Expectancy Has Changed Dramatically



1910	2010
1. Heart disease	1. Heart disease
2. Influenza & pneumonia	2. Cancer
3. Tuberculosis	3. Chronic lung diseases
4. Diarrhea/intestinal diseases	4. Stroke
5. Stroke	5. Accidents
6. Nephritis	6. Alzheimer's disease
7. Accidents (ex. motor vehicle)	7. Diabetes
8. Cancer	8. Nephritis
9. Premature birth	9. Influenza & pneumonia
10. Senility	10. Suicide

Source: National Center for Health Statistics–National Vital Statistics Service Reports, 2010.

limitations, and the shifting payment environment, the healthcare sector and community-based organizations (CBO) have begun partnering to integrate care and more effectively address the social determinants of health and functional limitations. CBOs for decades have been addressing social determinants of health: they know first-hand the value of meeting the person where they are, and addressing *all* of their needs.

The impacts of social determinants of health

There is now a greater understanding for how social determinants of health impact a person's health, function, and quality of life. Social determinants include social and economic status, health, education level, and the community in which a person lives, and are realized as access to affordable housing, transportation, services to support daily needs, access to healthcare, and residing in a safe and accessible environment (Office of Disease Prevention and Health Promotion, 2018).

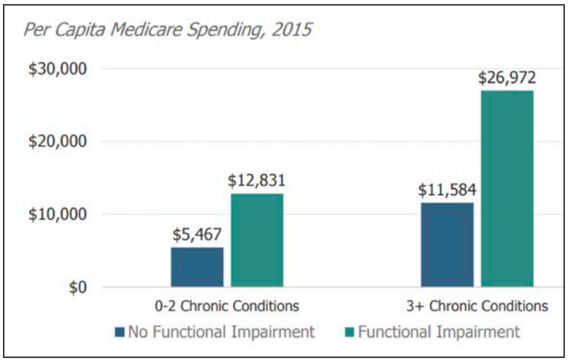
Older adults' healthcare needs can be ongoing and-or time-limited. In both cases, a healthcare intervention, or a response to those needs, often requires a mix of medical and social interventions. It has been accepted practice that before a healthcare organization can address a person's chronic conditions, it must address his or her immediate and ongoing needs. Basic needs, such as paying for rent or utilities and having access to food, must be considered before providers can expect people to eat healthily and exercise.

In a specific situation, such as transitioning from hospital to home after a case of pneumonia, the needs are more limited. These may be solved via 30-day interventions. These may be more clinical, but social interventions also are needed, such as transportation to follow-up appointments, and to pick up medications. In some cases, the needs can be determined as medically necessary, with some possibility of payment from Medicare and ongoing support through Medicaid waiver programs.

The impacts of policy shift

Since the 2010 passage of the Patient Protection and Affordable Care Act (ACA), we have seen a shift in policies that defines how care is provided. There has been increased attention to value-based purchasing, especially in the hospital setting (Centers for Medicare & Medicaid Services [CMS], and Medicare Learning Network, 2017). There has been a move toward services integration through the Financial Alignment Initiative, which is focused on dual eligible beneficiaries, who have both Medicare and Medicaid (CMS, 2018a). And new approaches to care delivery are being tested through entities such as Accountable Care Organizations (ACO) (CMS, 2018b) for Medicare Fee-for-Service.

Figure 2. Moderate Functional Impairment Associated with High Medical Costs



Source: The SCAN Foundation, 2018.

In 2018, The Bipartisan Budget Act was signed into law, which incorporated the Creating High-Quality Results and Outcomes Necessary to Improve Care (CHRONIC) Care Act (2017). The new law significantly advances policies related to providing integrated, person-centered care for Medicare beneficiaries and for those who are dually eligible for Medicare and Medicaid. The Act provides an opportunity for Medicare Advantage to provide supplemental benefits to cover the costs of some non-medical needs for high-need, high-cost beneficiaries. This also applies to those in permanently authorized Special Needs Plans (D-SNP; for dual eligibles), Chronic Condition Special Needs Plans (C-SNP; for people with chronic disabling conditions), Institutional Special Needs Plans (I-SNP; for institutionalized individuals), and provides greater flexibility to ACOs.

Heart disease, cancer, stroke, COPD, and diabetes account for 75 percent of healthcare spending.

A focus on population health management

With these opportunities, the healthcare sector has focused on population health management and social determinants of health. Population health management typically uses data to identify at-risk individuals and apply interventions to manage their health needs; and the healthcare sector employs diagnosis and claims data to target the highest utilizers. These are retrospective data, which means the healthcare sector begins the intervention after a person already has used healthcare services. For some providers, this means that the individual's needs are harder to address and support. There has been much discussion and early work to predict which patients might be future high utilizers, in order to anticipate needs and deploy an intervention before healthcare utilization begins (Figueroa et al., 2017; Joynt et al., 2017). Healthcare entities are still working out how to do this in a meaningful and cost-effective way.

Diagnosis and claims data provide only one picture of an older adult's health. Functional status is another major indicator of healthcare services use. Assessing an individual's functional status and acting upon that information is an effective strategy for identifying people who are high-risk and high-cost. Those providers participating in the Financial Alignment Initiative are required to conduct health risk assessments of their members. These assessments take into account all aspects of individuals' medical, biological, and psychosocial needs. To this end, the California Department of Health Care Services, in 2018, required plans to add ten questions specific to function to the health risk assessment (The SCAN Foundation, 2018). Additionally, in the 2019 Call Letter (CMS, 2018c), CMS recognized the importance of why a health risk assessment should include a functional assessment.

Healthcare Environment Continues to Evolve

The shift from volume to outcomes in healthcare continues to grow. There are several partnerships that have moved from pilots to ongoing sustainable collaborations for both parties. These early adopters have seen the benefits in improved quality of life for older adults but also in savings. Savings and benefits result from delaying institutionalization, reducing readmissions to hospitals, shortening hospital lengths of stay, and reducing emergency department visits. CBOs have made these benefits and savings possible through providing short-term and ongoing care management and care transitions, providing nutrition and transportation services, and linking older adults to other programs that offer housing, energy

'The shift from volume to outcomes in healthcare continues to grow.'

assistance, home modifications, and many other types of assistance.

The challenge continues to be how to expand the flexibility of healthcare dollars to cover the costs of community services. A community intervention often costs a fraction of a medical intervention. Health and social service sectors will need to continue to show that these interventions result in the same or better outcomes at a lower cost. Meeting the person where they are, understanding what they define as their greatest need, and responding to that need sounds easy conceptually but, in practice, the current system is not designed to support this approach to care.

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References

Better Medicare Alliance. 2017. "Understanding Risk Adjustment in Medicare Advantage." tinyurl.com/ya3k92xf. Retrieved October 22, 2018.

Centers for Medicare & Medicaid Services (CMS), and Medicare Learning Network. 2017. "Hospital Value-based Purchasing." tinyurl.com/lfed3dt. Retrieved October 22, 2018.

CMS. 2018a. "Financial Alignment Initiative." tinyurl.com/pn3wfcw. Retrieved October 22, 2018.

CMS. 2018b. "Accountable Care Organizations." tinyurl.com/pn3wfcw. Retrieved October 22, 2018.

CMS. 2018c. "NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties." tinyurl.com/ycak6kl2. Retrieved October 22, 2018.

Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. 2017. S. 870. 115th Cong. tinyurl.com/y9ej4lqu. Retrieved October 22, 2018.

Figueroa, J. F., et al. 2017. "Concentration of Potentially Preventable Spending Among High-cost Medicare Subpopulations: An Observational Study." *Annals of Internal Medicine* 167(10): 706–13.

Joynt, K. E., et al. 2017. "Segmenting High-cost Medicare Patients into Potentially Actionable Cohorts." *Healthcare* 5(1–2): 62–7.

Office of Disease Prevention and Health Promotion. 2018. "Social Determinants of Health." tinyurl.com/z32yfnv. Retrieved October 22, 2018.

Rudowitz, R., and Garfield, R. 2018. "10 Things to Know About Medicaid: Setting the Facts Straight." Henry J. Kaiser Family Foundation. tinyurl.com/y9toy8um. Retrieved October 22, 2018.

The SCAN Foundation. 2018. "Ten Questions to Better Understand and Serve Your Complex Care Population." tinyurl.com/yayjy5xn. Retrieved October 22, 2018.

Tumlinson, A., and Johnson, M. 2018. "CHRONIC Care Act: Making the Case for LTSS in Medicare Advantage Supplemental Benefits." The SCAN Foundation. tinyurl.com/ybrx6wtz. Retrieved October 22, 2018.

Wullianallur, R., and Raghupathi, V. 2018. "An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health." *International Journal of Environmental Research and Public Health* 15(3): 431.

Chronic Conditions, from A to Z

By Kathleen A. Cameron

> Life expectancy is lower in America than in other developed nations, mainly due to the toll of chronic conditions, many of which are preventable.

Life expectancy has increased notably since the beginning of the twentieth century, due to improvements in public health, nutrition, and medical technology. Today, the 10,000 baby boomers turning age 65 every day can expect to live another eighteen years (for men) to twenty years (for women) (Organisation for Economic Co-operation and Development, 2018).

However, the United States falls behind many countries in life expectancy, including Japan, Canada, most European and Scandinavian countries, and Australia. Millions of older adults in America struggle daily with challenges associated with chronic conditions, which are the leading causes of disability and death in the nation; these conditions explain, in large part, the differences in life expectancy between America and other countries (Heron, 2018).

> *'The United States falls behind many countries in life expectancy.'*

Good health is essential to ensuring longevity, as are independence, connectedness, sense of purpose, and security. Prevention and management of chronic conditions are key to maximizing health, well-being, and longevity.

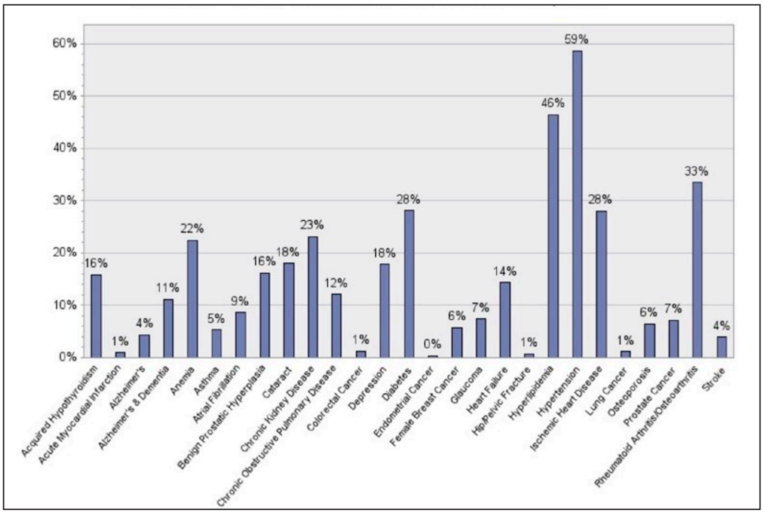
Facts About Chronic Conditions Among Older Adults

Chronic conditions are defined broadly as conditions that last one year or more and require ongoing medical attention, limit activities of daily living, or both. As shown in Figure 1 (see page 8), the top three conditions with the highest prevalence rates are hypertension (59 percent), hyperlipidemia (46 percent), and rheumatoid-osteoarthritis (33 percent). Nearly 30 percent of older adults has a diagnosis of ischemic heart disease (28 percent) and-or diabetes (28 percent). Anemia, chronic kidney disease, and depression each are present in about 20 percent of the Medicare population (Centers for Medicare & Medicaid Services [CMS], 2016).

Due to advances in treatment, certain cancers such as ovarian, chronic leukemias, and some lymphomas, as well as HIV/AIDS, are now considered chronic conditions (American Cancer Society, 2018; Siddigi et al., 2016). Alzheimer's

→ABSTRACT This article lays out what is known about the common chronic conditions in older adults, which segments of this population are most affected, and causation of conditions. The top three conditions in older adults are hypertension, hyperlipidemia, and arthritis. Chronic conditions, which have significant personal impacts on those affected, are the primary drivers of healthcare spending in the United States. Racial-ethnic, geographic, and socioeconomic groups are disproportionately impacted by chronic disease with causation tied to behaviors, socioeconomics, genetics, healthcare access and quality, and the environment. | **key words:** *chronic conditions, older adults, hypertension, hyperlipidemia, arthritis, prevention*

Figure 1. Medicare: CCW Condition Period Prevalence, 2016



Source: CMS. 2016. "Chronic Conditions Warehouse." tinyurl.com/ybztsv5y. Retrieved October 10, 2018.

disease is a chronic condition because an individual with this condition typically lives three to ten years after diagnosis, depending upon age at diagnosis (Brookmeyer et al., 2002). Behavioral health conditions, such as clinical depression, schizophrenia, bipolar disorder, and substance use disorders, also are chronic in nature.

Adults older than age 65 are disproportionally affected by multiple chronic conditions (MCC), with MCC prevalence increasing dramatically with age. Eighty percent of older adults have MCC, while only about half of all people ages 45 to 64 experience MCC (Gerteis et al., 2014). A recent study identified the following most prevalent two-condition combinations among inpatient older adult populations: hyperlipidemia and hypertension; hypertension and ischemic heart disease; diabetes and hypertension; chronic kidney disease and hypertension; anemia and hypertension; and hyperlipidemia and ischemic heart disease (He et al., 2018).

Another study showed that the three most prevalent combinations among non-institutionalized older adults are the following: hypertension and arthritis; hypertension, arthritis, and cardiovascular disease; and hypertension, arthritis, and diabetes (Quiñones, Markwardt, and Botoseneanu, 2016). This study also found that the combination of arthritis, hypertension, and depression resulted in the highest level of people's limitations in activities of daily living (ADL) and instrumental activities of daily living (IADL) compared to healthy participants or participants with a single disease.

Physical health and mental health conditions are fundamentally linked. People living with mental illness are at a higher risk of experiencing a wide range of chronic physical conditions. Conversely, people living with chronic physical health conditions experience higher rates of mental health conditions than does the general older adult population. For example, depression is found to co-occur in 17 percent of cardiovascular cases, in 23 percent of cerebrovascular cases, in 27 percent of diabetes patients, and more than 40 percent co-occurs in individuals who have cancer (Centers for Disease Control and Prevention [CDC], 2012). The association between depression and chronic disease appears attributable to depressive disorders precipitating chronic disease and to chronic disease exacerbating symptoms of depression (Chapman, Perry, and Strine, 2005).

Causes of Chronic Conditions

Most chronic conditions are caused by multiple factors, and premature death resulting from chronic conditions and poor health are influenced by determinants in the following five main areas: behavioral patterns (40 percent), socioeconomics (15 percent), genetic predisposition (10 percent), healthcare access and quality (10 percent), and environmental exposures (5 percent) (Schroeder, 2007).

The single greatest opportunity to improve health, prevent and manage chronic conditions, and reduce premature deaths is through healthy behaviors. Obesity, physical inactivity, and smoking are the leading causes of many chronic conditions, such as hypertension, heart disease, and diabetes. Other behavioral factors are poor nutrition, including diets low in fruits, vegetables, and whole grains, high in sodium and saturated fats, and in alcohol or other drug use. Eating healthily and performing regular physical activity help to prevent, delay, and manage heart disease, diabetes, and other chronic diseases. Older adults should aim for moderate physical activity (e.g., brisk walking) for at least 150 minutes a week, and should include exercises that build endurance, strength, balance, and flexibility.

'Physical health and mental health conditions are fundamentally linked.'

Smoking and excessive alcohol use also are associated with higher rates of chronic illness. Stopping smoking (or never starting) lowers the risk of serious health problems, such as cardiovascular disease, cancer, type 2 diabetes, and chronic obstructive pulmonary disease, as well as premature death. Over time, excessive drinking can lead to high blood pressure, many cancers, heart disease, stroke, and liver disease. By following drinking guidelines or not drinking at all, these health risks can be avoided.

People with lower socioeconomic status (SES) experience more chronic illness than those with higher SES. Factors related to SES are income, total wealth, education, employment, and neighborhood; these factors are tied to access and quality of care and people's health behaviors. For example, experiencing a dearth of venues for purchasing healthy foods (e.g., food deserts), lacking opportunities for recreation and physical activity, and being exposed to toxic environmental conditions, such as lead paint, polluted air and water, unsafe neighborhoods with few outlets for physical activity, all contribute to the development of chronic conditions and premature death. People with lower SES have greater exposure to these conditions, which directly influence their health.

Also to consider is genetic predisposition, or family history of a chronic disease, which may make people more likely to develop diseases such as sickle cell anemia, Alzheimer's disease, or certain types of cancer. Thus, knowing about one's family history is important to prevent conditions, or to identify and treat them early on.

Chronic Conditions and Health Disparities

Differences in health status or access to healthcare among racial, ethnic, geographic, and socioeconomic groups are referred to as health disparities. Health disparities exist in all age groups, including in the older adult cohort. Disparities in the burden of illness and death associated with chronic diseases experienced by African Americans, Hispanics, American Indians/Alaska Natives, and Asian Americans/Pacific Islanders, compared to the U.S. population at large, continue to be a problem. Examples include the following:

Hypertension: The disparity in hypertension and associated poor outcomes has been recognized for decades in African Americans compared to whites. African Americans experience an earlier onset of the condition and lower rates of control leading to higher rates of stroke, kidney disease, and congestive heart failure (Lackland, 2014).

Diabetes: The percentage of the U.S. adult population with diabetes varies significantly by race-ethnicity: American Indians/Alaskan Natives at 15.1 percent, Hispanics at 12.7 percent, and African Americans at 12.1 percent compared to whites at 7.4 percent (CDC, 2017).

Cancer: Overall, the United States has experienced declining cancer incidence and mortality rates due to reductions in tobacco use, greater uptake of prevention measures, adoption of early detection methods, and improved treatments. However, African Americans and individuals living in rural areas continue to have the higher cancer mortality rates and shorter survival times than other population groups in the nation (O'Keefe, Meltzer, and Bethea, 2015; Henley et al., 2017).

Alzheimer's disease: Consistent and adverse disparities exist among African Americans and Hispanics, compared to non-Hispanic whites, in the incidence of Alzheimer's disease, and related mortality. In addition, disparities exist in these two groups' participation in clinical trials, use of medications and long-term services and supports, healthcare expenditures, and quality of care received. More African Americans than Caucasians care for relatives with dementia, and they are less likely to ask for support. Caring for a loved one is considered a responsibility, not a burden (Alzheimer's Association, 2004). Therefore, the impact of caregiving may be greater for this population.

Despite overall declining cancer incidence and mortality rates, African American and rural American mortality rates are higher.

Demographic shifts that are taking place and leading to a more racially and ethnically diverse older adult population will magnify the importance of addressing disparities in the development of chronic conditions.

The Personal and Financial Impacts of Chronic Conditions

Chronic conditions are the leading causes of frailty, disability, and death in the United States. They lead to declines in ADLs and IADLs, causing individuals affected to lose their independence, and resulting in the need for help from family and-or paid caregivers, and-or requiring use of other long-term services and supports. Many people with chronic diseases restrict their social engagement with family, friends, and communities (Meek et al., 2018).

As the number of chronic conditions in people increases, complications associated with care are more common. Due to America's fragmented healthcare system, there occur more instances of unnecessary and often avoidable hospitalizations, duplicative and-or contraindicated medication prescribing, and scenarios in which patients receive conflicting advice from physicians and other healthcare providers. Functional limitations often complicate access to healthcare and interfere with self-management, which leads to elevated reliance upon caregivers (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, 2015).

Also, chronic conditions are leading drivers of our nation's $3.3 trillion in annual healthcare costs. They account for 71 percent of all healthcare costs (Gerteis et al., 2014) and 93 percent of Medicare fee-for-service spending (CMS, 2012). Medicare beneficiaries with multiple chronic conditions are the highest utilizers of healthcare services, such as physician and emergency department visits, hospitalizations, home health care, and prescription drugs. In addition, individuals with multiple chronic conditions face substantial out-of-pocket costs for their care, including more co-pays and higher costs for prescription medication.

Conclusion

Due to the heightened levels of chronic illness in the United States, along with the tremendous personal and financial costs associated with such illness, integrated approaches among clinical providers and community-based organizations are critically needed. Also, important to prevent further progression of chronic disease and onset of new conditions are broad-based implementation and payment mechanisms for self-management and engagement programs for those afflicted with chronic illness. Targeting racial-ethnic, geographic, and socioeconomic groups disproportionately affected by chronic disease with culturally appropriate prevention and management services and programs must be a priority in order to stem the tide of chronic illness in America.

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References

Alzheimer's Association, 2004. "Serving African American Families: Home and Community-based Services for People with Dementia and Their Caregivers." RTI International. tinyurl.com/y9ofoflf. Retrieved December 10, 2018.

American Cancer Society. 2018. "Managing Cancer as a Chronic Illness." tinyurl.com/yc7r4mor. Retrieved October 10, 2018.

Brookmeyer, R., et al. 2002. "Survival Following a Diagnosis of Alzheimer's Disease." *Archives of Neurology* 59(11): 1764–7.

Centers for Disease Control and Prevention (CDC). 2012. "Mental Health and Chronic Diseases" (Issue Brief 2). tinyurl.com/ycs5fcqp. Retrieved October 10, 2018.

CDC. 2017. "Addressing Health Disparities in Diabetes." tinyurl.com/ydd4hlcb. Retrieved October 10, 2018.

Centers for Medicare & Medicaid Services (CMS). 2012. *Chronic Conditions Among Medicare Beneficiaries, Chart Book 2012*. Baltimore, MD: CMS.

CMS. 2016. "Chronic Conditions Warehouse." tinyurl.com/ybztsv5y. Retrieved October 10, 2018.

Chapman, D. P., Perry G. S., and Strine, T. W. 2005. "The Vital Link Between Chronic Disease and Depressive Disorders." *Preventing Chronic Disease* 2(1): A14.

Gerteis, J., et al. 2014. *Multiple Chronic Conditions Chartbook: 2010 Medical Expenditure Survey Data* (AHRQ Publication No. Q14-0038). Rockville, MD: Agency for Healthcare Research and Quality.

He, Z., et al. 2018. "Prevalence of Multiple Chronic Conditions Among Older Adults in Florida and the United States: Comparative Analysis of the OneFlorida Data Trust and National Inpatient Sample." *Journal of Medical Internet Research* 20(4): e137.

Henley, S. J., et al. 2017. "Invasive Cancer Incidence, 2004–2013, and Deaths, 2006–2015, in Non-metropolitan and Metropolitan Counties—United States." *Morbidity and Mortality Weekly Report Surveillance Summary* 66(No. SS-14): 1–13.

Heron, M. 2018. "Deaths: Leading Causes for 2016." *National Vital Statistics Reports* 67(6). Atlanta, GA: CDC.

Lackland, D. T. 2014. "Racial Differences in Hypertension: Implications for High Blood Pressure Management." *American Journal of the Medical Sciences* 348(2): 135–8.

Meek, K. P., et al. 2018. "Restricted Social Engagement Among Adults Living with Chronic Conditions." *International Journal of Environmental Research and Public Health* 15(1): 158.

O'Keefe, E. B., Meltzer, J. P., and Bethea, T. N. 2015. "Health Disparities and Cancer: Racial Disparities in Cancer Mortality in the United States, 2000–2010." *Frontiers in Public Health* 3(51).

Organisation for Economic Co-operation and Development. 2018. "Life Expectancy at Age 65." tinyurl.com/yd6raxzh. Retrieved October 10, 2018.

Quiñones, A. R., Markwardt, S., and Botoseneaunu, A. 2016. "Multimorbidity Combinations and Disability in Older Adults." *The Journals of Gerontology, Series A: Biological Sciences and Medical Sciences* 71(6): 823–30.

Schroeder, S. A. 2007. "We Can Do Better—Improving the Health of the American People." *New England Journal of Medicine* 357(2): 1221–8.

Siddigi, A., et al. 2016. "Population-based Estimates of Life Expectancy After HIV Diagnosis: United States, 2008–2011." *Journal of Acquired Immune Deficiency Syndromes* 72(2): 230–6.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. 2015. "HHS Initiative on Multiple Chronic Conditions: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions." tinyurl.com/ybu7etfh. Retrieved October 10, 2018.

The **Role of Social Determinants** and Why Community-Based Programming Works

By Karen D. Lincoln

> Social needs often are not met during healthcare visits, but HCBS can fill that gap.

Health spending in the United States is projected to rise to $3.5 trillion in 2018, a 5.3 percent increase from 2017. Primary drivers of the increased spending include the aging population and growing prevalence of chronic conditions, which are difficult to treat and responsible for 85 percent of healthcare costs. Three in four Americans older than age 65 have two or more chronic health conditions, such as diabetes, hypertension, arthritis, or cancer. These individuals may struggle to manage their health in ways that allow them to maintain wellness and independence.

Despite the increasing costs associated with treating chronic conditions, individuals with chronic illness often do not make significant progress with their health conditions. Nearly one in five Medicare beneficiaries are readmitted to the hospital within thirty days of an initial discharge, and many more end up in the emergency department (Brennan, 2014). It is estimated that readmissions for Medicare beneficiaries cost $26 billion a year, of which an estimated $17 billion comes from potentially preventable re-hospitalizations.

Findings reported by the University of Wisconsin Population Health Institute indicated that many of the largest drivers of healthcare costs fall outside the clinical care environment (University of Wisconsin Population Health Institute, 2014). Only 20 percent of the modifiable variation in health outcomes is due to clinical care, whereas 40 percent is due to social and economic determinants, 30 percent to health behaviors, and 10 percent to the physical environment. This report came out just a few years after the Robert Wood Johnson Foundation's report called *Health Care's Blind Side*, which showed that 85 percent of primary care physicians and pediatricians indicated that unmet social needs—e.g., access to nutritious food, reliable transportation, and adequate housing—were leading to worse health for all Americans (Robert Wood Johnson Foundation, 2011).

➔ABSTRACT Social determinants of health—income, education, social inequality, living conditions, food security, environmental factors, and health behaviors—account for 80 percent of modifiable variations in health outcomes. They are key to improving health outcomes and optimizing healthcare resources. Unmet social needs are not typically detected or addressed by clinicians during healthcare visits; this increases risk of chronic conditions, reduces the ability to manage health conditions, and increases risk for morbidity, mortality, and institutionalization. Home- and community-based services fill the gap left by the healthcare system by addressing these needs. | **key words:** *social determinants of health, community-based programs, chronic conditions*

In 2016, the Affordable Health Communities initiative by the U.S. Department of Health and Human Services (HHS) announced that it was awarding $157 million dollars for projects that integrated social services with healthcare. The initiative's goal was to test whether screening beneficiaries for unmet health-related social needs, and increasing their awareness about and access to community-based services, would improve quality and affordability in Medicare and Medicaid. HHS recognized that over time, unmet social needs are not detected or addressed during typical healthcare-related visits, thus increasing the risk of developing chronic conditions and reducing an individual's ability to manage these conditions, all resulting in increased healthcare utilization and costs.

> *'Individuals with chronic illness often do not make significant progress with their health conditions.'*

Many health systems lack the infrastructure and incentives to develop systematic screening and referral protocols, or to build relationships with existing community service providers. Findings from *Hidden Hazards: Closing the Care Gap Between Physicians and Patients with Multiple Chronic Conditions*, a report from Quest Diagnostics (2018), showed that providers feel they are unable to address patients' comprehensive needs. Providers cite limited time, while patients' professed satisfaction with their care may mask social and behavioral risks and needs. These findings suggest that the traditional medical care model of an annual provider visit may be insufficient for those with multiple chronic conditions.

Findings from this study also indicated that 85 percent of providers say they were too pressed for time to address complex clinical issues, and 66 percent indicated that they do not have time to address social and behavioral issues, such as financial concerns or loneliness, that could affect their patients' health. More than four in ten patients (42 percent) thought that seeing their physician only one to two times per year to manage multiple conditions was "just not enough."

Social Determinants of Health

Social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the set of forces and systems shaping the conditions of daily life," according to the World Health Organization (Allen et al., 2017). Social determinants of health are indexed by factors outside of the individual, beyond genetic predispositions and individual behaviors. They are the contexts in which individual behaviors arise.

According to the National Research Council and the Institute of Medicine, the most important social factors determining health are income, accumulated wealth, education, occupational characteristics, and social inequality based on race and ethnic group membership (Woolf and Laudan, 2013). These variables have direct effects on other social determinants of health such as living conditions, food security, levels of stresses and strains, social disadvantages over the life course, environmental factors that influence unhealthy and healthy lifestyles, high- or low-risk health behaviors, biological outcomes through gene expression, and other connections to chronic diseases.

Regarding gene expression, epigenetics refers to external modifications to DNA that turn genes "on" or "off." Epigenetic change is a regular and natural occurrence, but also can be influenced by several factors including the environment, lifestyle, and disease state. A wide variety of illnesses, behaviors, and other health indicators have some level of evidence linking them with epigenetic changes, including cancer, cognitive dysfunction, and respiratory, cardiovascular, reproductive, autoimmune, and neurobehavioral illnesses (Weinhold, 2006).

The social context of a person's life, originating in childhood and accumulating over the life course, determines their risk of exposure, degree of susceptibility, and the course and out-

Photo: iStockphoto/ artisticco

come of a disease. A life-course perspective considers social determinants of health factors as flexible pathways determining health outcomes over time. Consequently, social determinants can initiate the onset of pathology and thus serve as a direct cause for a host of chronic conditions (Cockerham, Hamby, and Oates, 2017; Holtz et al., 2008).

The recognition that social determinants of health may be key to improving health outcomes and optimizing the use of healthcare resources has led to interest in creating strategies to manage the relevant material need insecurities of individuals (Doran, Misa, and Shah, 2014; Eggleston and Finkelstein, 2014; Garg, Jack, and Zuckerman, 2013). However, the knowledge base for this approach within healthcare systems remains limited.

One study provides some evidence of a link between social determinants of health and healthcare utilization. Berkowitz and colleagues (2015) examined the association between social determinants of health factors and diabetes control and healthcare utilization among 411 patients. Findings indicated that all material need insecurities had some association with poor clinical control or increased utilization. For example, food insecurity was associated with poor diabetes control and increased outpatient visits, while cost-related medication underuse was associated with poor diabetes, cholesterol, and blood pressure control, and emergency department and inpatient care utilization. Moreover, housing instability and energy insecurity were both associated with increased outpatient utilization.

Home- and Community-Based Services

Home- and community-based services (HCBS) are designed to help community-dwelling older adults remain safely in their homes and communities and delay or prevent entering long-term-care facilities. Between 2002 and 2012, the number of Medicaid HCBS participants increased from 2.3 to 3.2 million (Ng et al. , 2015). The growing demand for HCBS stems in part from the increasing size of the older population, older adults' desire to "age in place," and increased federal pressure on states, most recently from the Affordable Care Act of 2010, to provide HCBS options that may help reduce spending on nursing homes.

HCBS address many social determinants of health factors by providing resources for older adults and their caregivers, such as wellness and nutrition programs, supportive services (e.g., shopping, money management, house and yard work, meal preparation, toileting, dressing, bathing, and medication management), job training, senior centers, transportation, health promotion, and family caregiver support programs. HBCS also provide opportunities for community and civic engagement through various volunteer programs (National Association of Area Agencies on Aging, 2011).

> *'Social determinants can initiate the onset of pathology and serve as a direct cause for a host of chronic conditions.'*

More than 20 percent of adults ages 60 and older receive HCBS (Greenlee, 2013). More than 90 percent of these service users have multiple chronic conditions (Kleinman and Foster, 2011) and related functional impairment (Barrett and Schimmel, 2010). With the rapid aging of the U.S. population, and the growing diversity of older adults (many of whom are Medicaid beneficiaries and have multiple chronic conditions), the number of individuals who could benefit from HCBS is expected to increase dramatically during the next two decades. Costs and consumer preference have led to a shift from skilled nursing facilities as the primary long-term-care option to HCBS. AARP research shows that 90 percent of people would like to age in their home and community (Farber et al., 2012), and they expect professional care to be provided in communities rather than only in institutional settings.

Few studies examine the outcomes of HCBS. Those studies that do are focused on the cost-effectiveness of HCBS compared to nursing homes (Doty, 2000). Findings from these studies revealed that expanding access to HCBS increased aggregate long-term-care expenditures (that is, total long-term-care spending, including spending for nursing homes and spending for HCBS combined). More specifically, these demonstration projects showed a substantial increase in HCBS use and a modest decrease in nursing home use. However, demonstration projects that targeted services to individuals who had both high levels of functional impairment and high risk of nursing home placement saw reductions in cost.

If HCBS programs must be "budget neutral" to be deemed successful, they will fail the test. Budget neutrality is not the metric for success when it comes to Medicaid hospital payments or expenditures for physician services. Rather, success should be defined by other measures, including analysis of broader social criteria, to determine if the good HCBS programs do outweigh their cost by more than the good that could be obtained by spending the same amount of money in alternative ways.

One study examined the effects of community-based services on the subjective well-being, probability of institutionalization, and mortality of underserved community-dwelling older adults (Shapiro and Taylor, 2002). Findings indicated that early provision of in-home social services was positively associated with older adults' subjective well-being and negatively associated with permanent nursing home placement and mortality. In addition, participants who received early provision of in-home social services were significantly less depressed, had a greater sense of satisfaction with their lives overall and with their social relationships, had a greater degree of mastery of over their environment, and were less likely to die or experience permanent nursing home placement than those who did not receive these services.

My work demonstrates the importance of community-based programs for older African Americans. In the report, *New Research High-*

lights the Benefits of Community Programs for Older African Americans in Los Angeles County, findings indicated that participation in programs and services for older adults was associated with higher quality of life, less loneliness and isolation, and less food insufficiency (Lincoln, 2015a). One of the most significant service-related factors associated with the health and well-being of African American older adults was whether they felt that services were missing from their neighborhood. African American older adults who felt that services were missing, such as home-delivered meals, transportation, In-Home Supportive Services, and adult daycare, were more likely to report *fair* or *poor* mental health, a lower quality of life, more loneliness and isolation, food insufficiency, and poor medication adherence compared to those who had services in their neighborhood.

Residents of nations with higher ratios of spending on social services versus healthcare have better health and live longer.

The effectiveness of HCBS for older adults and their families cannot be captured solely with measures of cost-effectiveness. However, if cost is the primary measure, then the cost reductions associated with improved subjective well-being and quality of life, less loneliness and isolation, less depression and food insufficiency, better medication adherence, and lower mortality should be taken into account.

HCBS are important prevention and intervention strategies that can reduce the impact of social determinants of health upon the health and well-being of older adults. This is especially the case for poor and minority older adults, who have an increased risk of being placed in low-quality skilled nursing facilities for care that they could otherwise receive at home or in the community (Lincoln, 2014, 2015b).

Conclusion

The United States spends far more money per capita on medical services than do other nations, while spending less on social services (Tran, Zimmerman, and Fielding, 2017). Residents of nations that have higher ratios of spending on social services to spending on healthcare services have better health and live longer (Bradley et al., 2016) than do residents of the United States. More investment in addressing social determinants of health would, in contrast to current policies, achieve better population health, lessen inequality, and lower healthcare costs. Such an investment could expand programs, improve quality, and increase access to culturally relevant, coordinated services for older adults—elevating their and their families' quality of life and significantly reducing healthcare costs by helping them remain in their homes and communities for as long as possible.

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References

Allen, J., et al. 2017. "Social Determinants of Health." *International Review of Psychiatry* 26(4): 392–407.

Barrett, A., and Schimmel, J. 2010. *OAA Title III Services Target the Most Vulnerable Elderly in the United States*. Washington, DC: Administration on Aging.

Berkowitz, S. A., et al. 2015. "Material Need Insecurities, Control of Diabetes Mellitus, and Use of Health Care Resources Results of the Measuring Economic Insecurity in Diabetes Study." *JAMA Internal Medicine* 175(2): 257–65.

Bradley, E. H., et al. 2016. “Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000–09.” *Health Affairs* 35(5): 760–8.

Brennan, N. 2014. “Real-time Reporting of Medicare Readmissions Data.” *Findings from Recent CMS Research on Medicare*. Washington, DC: Centers for Medicare & Medicaid Services.

Cockerham, W. C., Hamby, B. W., and Oates, G. R. 2017. “The Social Determinants of Chronic Disease.” *American Journal of Preventive Medicine* 52(1): S5–12.

Doran, K. M., Misa, E. J., and Shah, N. R. 2014. “Housing as Health Care: New York’s Boundary-crossing Experiment.” *Obstetrical & Gynecological Survey* 69(4): 195–7.

Doty, P. 2000. *Cost-Effectiveness of Home- and Community-Based Long-Term-Care Services*. Washington, DC: U.S. Department of Health and Human Services.

Eggleston, E. M., and Finkelstein, J. A. 2014. “Finding the Role of Health Care in Population Health.” *Journal of the American Medical Association (JAMA)* 311(8): 797–8.

Farber, N., et al. 2012. *Aging in Place: A State Survey of Livability Policies and Practices: A Research Report by the National Conference of State Legislatures and the AARP Public Policy Institute*. Washington, DC: The National Academies of Science, Engineering, and Medicine.

Garg, A., Jack, B., and Zuckerman, B. 2013. “Addressing the Social Determinants of Health Within the Patient-centered Medical Home: Lessons from Pediatrics.” *JAMA* 309(19): 2001–2.

Greenlee, K. 2013. *FY 2012 Report to Congress*. Washington, DC: U.S. Department of Health and Human Services, Administration on Aging, Administration for Community Living.

Holtz, T. H., et al. 2006. “Erratum: Health Is Still Social: Contemporary Examples in the Age of the Genome.” *PLoS Medicine* 3(10): e419.

Kleinman, R., and Foster, L. 2011. *Multiple Chronic Conditions Among OAA Title III Program Participants*. Washington, DC: Administration on Aging.

Lincoln, K. D. 2014. “Minorities Are Forced into Nursing Homes at Greater Rates.” *The New York Times*, September 25. tinyurl.com/y842hr4t. Retrieved October 2, 2018.

Lincoln, K. D. 2015a. *New Research Highlights the Benefits of Community Programs for Older African Americans in Los Angeles County*. Los Angeles: Advocates for African American Elders.

Lincoln, K. D. 2015b. “Increasing Long-term-care Options for Low-income Seniors.” *About.com*, April 1, 2015. tinyurl.com/ycc2owgp. Retrieved November 7, 2018.

National Association of Area Agencies on Aging (n4a). 2011. *The Maturing of America—Communities Moving Forward for an Aging Population*. Washington, DC: n4a

Ng, T., et al. 2015. “Medicaid Home and Community-based Services Programs: 2012 Data Update.” The Henry J. Kaiser Family Foundation (November): 16–48.

Quest Diagnostics. 2018. *Hidden Hazards: Closing the Care Gap Between Physicians and Patients with Multiple Chronic Conditions*. tinyurl.com/y9q5avgq. Retrieved October 2, 2018.

Robert Wood Johnson Foundation. 2011. *Health Care’s Blind Side: The Overlooked Connection Between Social Needs and Good Health*. Princeton, NJ: Robert Wood Johnson Foundation.

Shapiro, A., and Taylor, M. 2002. “Effects of a Community-based Early Intervention Program on the Subjective Well-being, Institutionalization, and Mortality of Low-income Elders.” *The Gerontologist* 42(3): 334–41.

Tran, L. D., Zimmerman, F. J., and Fielding, J. E. 2017. “Public Health and the Economy Could Be Served by Reallocating Medical Expenditures to Social Programs.” *SSM—Population Health* 3: 185–91.

University of Wisconsin Population Health Institute. 2014. *County Health Rankings, Key Findings 2014*. Madison, WI: University of Wisconsin Population Health Institute.

Weinhold, B. 2006. “Epigenetics: The Science of Change.” *Environmental Health Perspectives* 114(3): A1607.

Woolf, S. H., and Laudan, A., eds. 2013. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington, DC: The National Academies Press.

Medicare Advantage: Modernizing Medicare Through Innovation in Financing and Care Delivery

By Allyson Y. Schwartz

Medicare Advantage plans, which are improving patient outcomes, offer a better path forward for Medicare.

The aging of our nation's population will place new demands on every sector of society, and no sector will be more adversely affected than the healthcare system. With 10,000 people turning age 65 every day, the number of older Americans is projected to double in the next few decades, growing from 48 million in 2018 to 98 million by 2060, at which point nearly one in five Americans will be ages 65 or older.

> *'The fee-for-service system created by traditional Medicare is fragmented and ill-suited for today's needs.'*

How we meet these new demands on the healthcare system is an ongoing conversation in Washington, D.C., with an expected divide breaking down on whether the answer is to cut spending or garner new revenue, or enact some combination of the two. While policy makers are focused on the financial pressures on Medicare (as the largest payer of healthcare for older adults), there is an increasing realization that an important part of the solution is to modernize Medicare financing and care delivery to better to meet the needs of today's and tomorrow's older adults.

Medicare Beneficiaries' Changing Healthcare Needs

The health needs of older Americans have changed dramatically over time. The healthcare financing system established in 1965 with Medicare was designed to meet the concerns and reality of the day. Fifty years ago, older Americans needed help to pay for acute episodes of care that meant a hospital stay, which was unaffordable for most elders. Medicare addresses these expensive hospitalizations and accompanying services by covering the majority of the cost of hospital stays, associated physician services, tests, and procedures. Providers are reimbursed

➜ABSTRACT Older adults are living longer with more chronic conditions and benefit from person-centered care that also addresses social determinants of health. Integrated, value-based care can better serve the Medicare population's changing healthcare needs. This article explores the way Medicare Advantage (MA) is modernizing Medicare financing and care delivery to meet the needs of today's and tomorrow's older adults, and how MA plans have shown improved outcomes for beneficiaries with chronic illness. | **key words**: *traditional Medicare, Medicare Advantage, chronic conditions, social determinants of health, integrated care, person-centered care, value-based care*

for covered benefits on a fee-for-service basis, with rates set by the federal government. Beneficiaries pay a deductible and co-payments, with many also purchasing supplemental coverage for outpatient and physician services.

The fee-for-service system created by traditional Medicare is fragmented and ill-suited for today's needs. While there still are people who will contract acute illnesses and inpatient care is a necessary and important part of all healthcare coverage, the field of medicine has become much more complex, with more specialists, treatments, and medications. The result, most significantly, is that more older adults are living longer with chronic conditions that need long-term management.

Older adults with chronic conditions are growing in number, as are the quantity of conditions they need help managing. They see multiple specialists, many of whom do not coordinate with each other. On average, Medicare patients see seven different physicians in four practices (Pham et al., 2007). Three in four adults older than age 65 have multiple chronic conditions (Gerteis, 2014). Seventy-seven percent have at least two conditions, and 14 percent have six or more (National Council on Aging, 2018). Those with multiple conditions account for 93 percent of fee-for-service Medicare costs each year (Gerteis, 2014). These are high-need, high-cost individuals who require ongoing clinical and support services in an integrated care system that can help them to manage their conditions and to live full and healthy lives.

The importance of integrated, value-based managed care

An integrated system, in which payments and benefits align to incentivize integrated care that encourages primary care, early intervention, and care management, is a better solution. This alternative exists in Medicare today—it is called Medicare Advantage (MA). The MA system is based on risk-based capitated payments to cover Medicare benefits, offered by private health plans, with accountability for provider adequacy and quality performance. And, it is increasingly the choice for Medicare-eligible beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) projects that the number of individuals choosing MA will grow to 22.6 million in 2019, which will account for 36.7 percent of the Medicare population (CMS, 2018). This represents an 11.5 percent increase from 2018, which had been the largest increase in recent years. Nationally, there are 3,700 MA plans, with more than 91 percent of beneficiaries having access to ten or more plan options in their region. Most of these plans offer both Medicare hospital and physician benefits, as well as Part D prescription drug coverage, along with supplemental benefits not covered by traditional Medicare. These benefits typically include dental, hearing, and vision care, wellness programs, and reduced cost-sharing with lower premiums and annual out-of-pocket costs for the beneficiary. MA premiums are low, with 2019 average monthly premiums about $28, and half of enrollees are enrolled in zero premium plans.

The risk-based capitated system of financing healthcare in MA has led to a transformation in care delivery, enabling providers to offer person-centered care that focuses on primary care teams. According to recent report by the Health Care Payment Learning & Action Network, nearly 50 percent of providers under contract to MA plans are in alternative payment arrangements, with providers assuming some level of financial risk (Health Care Payment Learning & Action Network, 2018). This is significantly higher than traditional Medicare, and much higher than in commercial insurance. These plans and providers work together to address shortfalls in care and build innovative ways to offer care that are improving outcomes—at the same or lower cost than traditional Medicare.

MA's Innovations in Care Delivery

Three approaches described below illustrate the care delivery innovations underway in MA. First is the focus on primary care, early intervention, and care management. Second are the opportunities available in Special Needs Plans (SNP) in MA, and third are the increasing flexibilities available to MA plans to offer supplemental benefits.

Person-centered care management

Integrated care is built upon several principles essential to its success in addressing the needs of people who have serious chronic conditions. A 2017 report sponsored by the Better Medicare Alliance and issued by the Robert Graham Center highlighted several primary care providers and identified the essential elements of successful care management (Better Medicare Alliance, 2018).

The findings and showcased examples all indicate that successful person-centered care management requires the following:

√ A financing mechanism that offers financial incentives for improved outcomes over volume of services, encourages innovation, and allows flexibility to meet the person's needs;

√ An organizational culture that promotes and supports care management, invests in the necessary infrastructure of staff and operations, and supports sustained staff education and training;

√ Effective teams that routinely communicate with each other, define roles and responsibilities, and attend to care transitions;

√ Active use of risk stratification data to identify and address peoples' needs, individualized care plans that are operationalized, and actions aimed at removing barriers to care; and

√ Trust among providers at all levels, recognition of the need to build relationships with each other and with the people under their care, and shared decision-making.

MA Special Needs Plans

MA plans are using their risk-based, capitated systems to identify high-risk beneficiaries and to intervene and engage them early and where they are, both physically and mentally. One of MA's unique aspects involves the opportunity to develop and implement SNPs for targeted populations with complex needs. SNPs may target populations of people who are frail, have disabilities, or are chronically ill. There are three types of SNPs: D-SNPs available for those individuals who are dually eligible for Medicare and Medicaid; C-SNPs for people with chronic conditions; and I-SNPs for individuals who are eligible for institutional care.

Each type of plan is required to establish a care model that identifies the population, establishes protocols for care coordination and care transitions, operationalizes a provider network appropriate to the population, and reports quality measurements. Each beneficiary has a customized treatment plan. There are almost 700 SNPs across the country, and they are showing lower rates of hospitalizations, more care provided in the home, and lower readmission rates.

Fourteen percent of older adults have six or more chronic conditions and need long-term-care management.

Supplemental benefits and new flexibilities in MA

MA plans offer supplemental benefits not covered in traditional Medicare. These benefits are offered using rebate dollars available to plans that bid below the adjusted benchmarked cost for traditional Medicare beneficiaries. These rebates also are adjusted based on the plans' quality performance, with high-quality plans receiving an extra financial bonus for meeting quality measurements. The plans are required to use these rebate dollars to directly benefit their enrollees. Such benefits include reduced cost-sharing, dental, vision, and hearing benefits, wellness programs, and, more recently, telemedicine.

Almost all plans offer at least one additional benefit and 50 percent of plans offer at least three supplemental benefits. Due to the CHRONIC Care Act's enactment, the types of benefits that plans can offer have been limited to services that are “primarily health-related” and benefit offerings must be approved by CMS. CMS recently expanded the definition of allowable benefits to define “primarily health-related” to include any service that allows for the diagnosis, prevention, or treatment of an illness or injury; that compensates for physical impairments; that ameliorates the functional/psychological impact of injuries or health conditions; or that reduces avoidable emergency or healthcare utilization.

This has meant new opportunities for plans to offer targeted populations caregiver support, in-home modifications, direct care in the home, and other services that may be expected to compensate for physical impairments, address impact of injuries or health conditions, or reduce avoidable hospital use.

This definition of allowable supplemental benefits will be further expanded in 2020, as a result of congressional action intended to address the needs of individuals with chronic conditions. This action is in response to the recognition of the role social determinants of health play in achieving better patient outcomes. Lack of transportation and in-home supports, food insecurity, and functional impairments all have been seen to have an impact on a person’s capacity to improve his or her health status. Unlike traditional Medicare, MA can identify populations of beneficiaries in need and deliver these additional benefits to address the social determinants of health.

MA beneficiaries with chronic conditions used fewer high-cost services, more preventive services and screenings, and had better outcomes.

These new efforts will be tested in the years ahead, and can yield valuable lessons for reforming MA and, possibly, traditional Medicare. It remains to be seen if the potential impacts of these efforts in transforming financing, benefits, and care delivery can meet the needs of Medicare beneficiaries, particularly those having complex needs.

MA Shows Outcomes Improvement in Chronic Conditions

The opportunities inherent in MA to improve healthcare and outcomes at the same or lower costs than traditional Medicare have been reported in numerous small-scale studies over the years. However, it was not until July 2018 that a research report from Avalere Health offered findings from a large-scale national comparative analysis that found outcomes in MA were better for high-need, chronically ill beneficiaries than in traditional Medicare (Mendelson, Teigland, and Creighton, 2018).

Sponsored by Better Medicare Alliance, the research compared demographic, cost, utilization, and quality metrics for 1.6 million MA beneficiaries and 1.2 million beneficiaries in traditional Medicare with one of the selected chronic conditions of hypertension, hyperlipidemia, and diabetes.

While the two study populations had similar demographic profiles, MA had a higher proportion of beneficiaries with clinical and social risk factors shown to affect outcomes and cost. This included a 15 percent higher likelihood of being dually eligible, a 57 percent higher rate of serious mental illness, and a 16 percent higher rate of substance abuse.

Despite this higher proportion of risk factors, MA beneficiaries with chronic conditions experienced lower use of high-cost services, higher rates of preventive services and screenings, and better outcomes.

Specifically, for the study population, MA achieved 23 percent fewer inpatient hospital stays, 33 percent fewer emergency room visits, and a 29 percent lower rate of potentially avoidable hospitalizations. They also experienced a 13 percent higher rate of LDL (low-density lipoprotein) cholesterol testing and a 5 percent higher rate of breast cancer screening.

Finally, for the two highest need cohorts, those who are dually eligible for Medicare and Medicaid and those with diabetes, the rates were even higher in reduced, potentially avoidable admissions, lower rates of complications, and lower per-beneficiary costs.

These findings build on the growing body of evidence that MA is providing high-value care through innovations in care delivery and payment arrangements, which are satisfying the needs of beneficiaries, including those having complex needs.

Conclusion

MA's managed care framework offers greater simplicity, affordability, and enhanced benefits that improve healthcare and well-being for millions of individuals in Medicare. With policy and payment stability, and increasing investment and enrollment, MA plans offer a path toward a brighter future for Medicare.

Former Congresswoman Allyson Y. Schwartz (D-PA) is president and CEO of Better Medicare Alliance, based in Washington, D.C.

References

Better Medicare Alliance. 2018. *Spotlights on Innovation*. tinyurl.com/ybjrwmvd. Retrieved November 1, 2018.

Centers for Medicare & Medicaid Services (CMS). 2018. *Fact Sheet: 2019 Medicare Advantage and Part D Prescription Drug Program Landscape*. tinyurl.com/yc9m6s3b. Retrieved November 1, 2018.

Gerteis, J., et al. 2014. *Multiple Chronic Conditions Chartbook*. Rockville, MD: Agency for Healthcare Research and Quality.

Health Care Payment Learning & Action Network. 2018. *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service Programs*. tinyurl.com/y9swvtus. Retrieved November 1, 2018.

Mendelson, D., Teigland, C., and Creighton, S. 2018. *Medicare Advantage Achieves Better Health Outcomes and Lower Utilization of High-Cost Services Compared to Fee-for-Service Medicare*. Washington, DC: Avalere Health. tinyurl.com/yanort28. Retrieved November 1, 2018.

National Council on Aging. 2018. "Healthy Aging Facts." tinyurl.com/yc8fzcvr. Retrieved November 1, 2018.

Pham, H. H., et al. 2007. "Care Patterns in Medicare and Their Implications for Pay for Performance." *New England Journal of Medicine* 356(11): 1130–9.

New Strategies for Condition Management Within Value-Based Care

By Robert Fields

> Managing chronic conditions must involve behavior change, new data sources, and new clinical roles.

Increasing costs and poor national outcomes have forced stakeholders such as government, health systems, and providers to redirect their efforts toward value-based care. Health systems, previously a loose mix of employed and affiliated medical staff, are organizing into Accountable Care Organizations (ACO)—networks of hospitals, medical practices, and other providers of health services focused on managing populations to reduce care costs, while improving the quality of care. As a result, new strategies, such as partnering with community-based organizations (CBO) to manage social determinants of health—not routinely part of delivery systems or condition-management programs—are emerging as necessary steps to achieve population-health goals. ACOs and other value-based models have forced an upstream approach to managing populations in order to avoid downstream costs.

The renewed focus on primary and secondary prevention is a welcome approach in a system that has historically concentrated on disease-specific care, which provides most of its interventions long after the diagnosis of illness and-or its complications have manifested. As ACOs take on increasing risk and quality metrics, and outcomes become a key part of the strategy, they must adapt condition-management programs to include new technologies and new insights into behavior change, as well as to expand partnerships with community organizations that can reduce barriers for older adults and help them achieve better health.

Key Elements of Condition-Management Programs

Education is at the core of all condition-management programs. While most frontline providers use Electronic Medical Record (EMR)–based education, the most effective models employ a more individualized approach tailoring this education to the person's needs and health literacy levels. Such programs often use baseline assessments to match the appropriate education to the

→ABSTRACT Accountable Care Organizations are an increasingly common value-based care model emphasizing quality and outcomes. This shift has forced providers to think creatively about managing chronic conditions to avoid complications, poor outcomes, and increased costs. New technologies in self-management and remote monitoring and strategies to promote behavior change can drive clinical outcomes. Recognizing the relationship between social determinants of health and achieving clinical goals has encouraged stronger relationships between delivery systems and community-based organizations to foster better healthcare decisions | **key words**: *Accountable Care Organizations, value-based care, social determinants of health, patient education, technology*

person so that a person with low health literacy, for example, may receive information via video or written text that is accessible and easy to comprehend, while a more educated, highly engaged individual may do well with self-directed learning modules, books, or other resources.

Education increasingly is delivered via interactive websites, portal-delivered handouts, video, and other avenues. Despite new technology, education for many people is best delivered through a relationship-based approach using health coaches, certified diabetes educators (CDE), and other human resources. These professionals can gauge body language, facial expressions, and other non-verbal forms of communication to help determine patients' comprehension levels. Using teach-back methods to measure patient understanding can be very effective in making sure these education efforts achieve desired outcomes (Simmons et al., 2014; Barello et al., 2016).

Team collaboration: the role of the clinical pharmacist

Clinical pharmacists are emerging as a valuable resource in the ambulatory setting to assist in condition management. Most states have regulations allowing collaborative practice agreements with physicians such that pharmacists, under protocol, can prescribe medication and bill for patient visits. In many settings, physicians and other providers diagnose the condition and set the treatment plan. The clinical pharmacist on the care team can then independently reach out to and visit with the patient to provide education and self-management support, and also titrate medications to achieve clinical goals.

This approach fosters active management between physician visits, thereby reducing the time it takes to reach the patient's clinical goals. Health plans and ACOs also have used pharmacists to help with issues such as medication access and adherence, which often are barriers for people in managing chronic illness. In collaboration with health coaches, CDEs, and other educators, clinical pharmacists can be an effective resource for supporting self-management. Teaching a person to self-administer medication, check blood sugar or other readings, and self-titrate medication in response to monitoring all are examples of skills that clinical pharmacists commonly teach (Greer et al., 2015).

The promise—and challenges—of technology

Increasingly, technology plays a role in chronic condition management and affects many parts of the care model. For instance, wearables (e.g., watches, heart-rate monitors, continuous glucose monitors, lenses) are providing new data inputs that in some cases feed directly into patient portals or other interfaces. Remote monitoring of glucose levels and blood pressure, for example, has become commonplace. These new data inputs are promising, but given the potential volume of information, most systems struggle to appropriately filter that data and provide actionable information to physicians and other caregivers. Health systems must design policies and procedures to execute these programs effectively without creating "noise" for providers and other caregivers.

Value-based care models use an upstream approach to managing populations in order to avoid downstream costs.

Beyond wearables, new companies have emerged that combine remote-monitoring technology and health coaches to guide patients toward positive behavior change. The most common examples are in managing diabetes and hypertension, but also they exist for other conditions such as chronic obstructive pulmonary disease and heart failure. In these cases, the person provides data via a glucometer, scale, or other home diagnostic equipment. That information is transmitted to a remote health coach or another professional who can provide feedback, in real time, to the person via the device or smartphone.

This level of real-time interaction is promising, but also creates new communication challenges. Again, technology design processes must consider the filtering and collection of relevant information and close the loop on both the clinical data elements and interventions so that the managing primary care providers and specialists can know which changes were made. Health systems must be careful not to add to fragmentation as healthcare providers expand members of the care team to include those in remote settings (Chiauzzi et al., 2015).

Social Determinants of Health: Closing the Gaps in Care

Health plans and ACOs increasingly are tackling the social determinants of health, as awareness of their effects upon health outcomes and cost has increased. Often, condition-management programs are responding accordingly by screening for social determinant barriers and partnering with CBOs to help close those gaps.

Remote monitoring of glucose levels and blood pressure has become commonplace.

Again, technology can be helpful in this work by collecting information on social determinants using novel methods (e.g., through app-based patient screens, by purchasing credit, census, or other data from data brokers) and by finding ways to meaningfully engage with CBOs beyond a simple referral. These engagements include sharing data elements, care plans, and other key pieces of information that help both parties to work with the person. Many organizations have included CBOs in patient-focused discussions, along with physicians and office staff, so that they can more easily identify new opportunities to help people and discuss care goals. One challenge for ACOs and health plans is how they will include CBOs in the financing of healthcare as CBOs play a larger role in caring for people having complex conditions.

The most critical but often poorly studied strategy in any condition-management program is that which can affect behavior change and support engagement. In standard care environments, individuals who are unwilling to change their behaviors around diet, exercise habits, or medication adherence often are labeled “noncompliant”—without any regard for the complexity of factors that influence such resistance to behavior change. Influencing behavior then requires first understanding the greater life context of each person. Assessments can begin to tell the person’s story, but to encourage and direct them toward a healthier path, a provider must also use relational skills, such as active listening and motivational interviewing, to establish a sense of trust.

Using individualized education, as mentioned previously, also can influence behavior. Giving a large volume of complicated information to a person who is not well-informed about their condition or who is not fully accepting of its potential risks, is not likely to be effective. The need for mass customization in engagement has pushed technology to adapt to various stages of the behavior-change model. Again, a combination of technology and therapeutic relationships is helpful in establishing trust and motivating positive change.

The Path Forward in a Value-Based World

In a value-based world where health provider organizations’ sustainability depends upon achieving good outcomes and avoiding the complication of chronic disease, condition-management programs, if they are to succeed, must reinvent themselves from being primarily education programs to those that focus more deliberately on behavior change, the use of new data sources, and new clinical roles.

Creative and effective examples exist across the country, notably the Centers for Medicare &

Medicaid Services' Medicare Diabetes Prevention Program (tinyurl.com/ycs3n8l8) and the American Diabetes Association's Diabetes Prevention Program (tinyurl.com/yaf3738d), both of which have been proven to promote weight loss, reduce blood pressure, and improve lipid profiles. Programs like these are resource-intensive in the short term, but that reality pales in comparison to the astronomical costs of caring for an aging, increasingly overweight, and at-risk population.

Individualized education can influence behavior.

Though there is a growing body of evidence about what works to manage chronic conditions, the question is, who will pay for these interventions? Historically, those on commercial, employer-based plans changed plans every three to five years, there was little incentive for providers to invest in the most effective condition-management programs. Perhaps the greatest contribution of the ACO movement, when it comes to both preventive care and condition-management programs, is that financial incentives are better aligned toward doing what is best for people, and that providers are being encouraged to move from reactive to proactive care.

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References

Barello, S., et al. 2016. "eHealth for Patient Engagement: A Systematic Review." *Frontiers in Psychology* doi: 10.3389/fpsyg.2015.02013.

Chiauzzi, E., et al. 2015. "Patient-centered Activity Monitoring in the Self-management of Chronic Health Conditions." *BMC Medicine* 13: 77.

Greer, N., et al. 2015. "Pharmacist-Led Chronic Disease Management: A Systematic Review of Effectiveness and Harms Compared to Usual Care." *Annals of Internal Medicine* doi: 10.7326/M15-3058 (ePub ahead of print).

Simmons, L. A., et al. 2014. "Patient Engagement as a Risk Factor in Personalized Health Care: A Systematic Review of the Literature on Chronic Disease." *Genomic Medicine* 6(2): 16.

The CHRONIC Care Act: Expanding Access, Extending Medicare's Focus

By G. Lawrence Atkins and Andrew L. MacPherson

> The Act begins a shift toward building home- and community-based support for people with chronic conditions.

Medicare beneficiaries who live with multiple chronic conditions present the most complex array of care needs and rely heavily on medical care, behavioral healthcare, and long-term services and supports (LTSS). Medicare beneficiaries with four or more chronic conditions account for 90 percent of Medicare hospital readmissions, and 74 percent of overall Medicare spending (Bipartisan Policy Center, 2018). Despite the impact that chronic conditions have on healthcare spending, there have been few major legislative initiatives that have focused on improving outcomes and lowering costs for people living with chronic conditions.

Recognizing this, a bipartisan group of lawmakers worked to develop legislation to support better management of chronic diseases in public programs. Following a multi-year process with two-rounds of stakeholder input led by Senators Johnny Isakson (R-GA) and Mark Warner (D-VA), the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2018 was developed, introduced, and ultimately passed by the Congress. On February 9, 2018, the president signed the Bipartisan Budget Act of 2018 (Public Law 115-123) into law, which included as Title III the CHRONIC Care Act.

Provisions of the CHRONIC Care Act

The CHRONIC Care Act makes changes in the Medicare program in several areas; these changes are aimed at expanding access to high-quality care at home for beneficiaries living with one or more severe chronic conditions. The Act has two major areas of focus: improving access to primary care, and expanding opportunities for in-home supports and services.

As stated above, one major focus of the Act is to encourage greater reliance on primary care, thus reducing unnecessary and avoidable medical care and hospitalization. It does this by:

√ Providing an opportunity for beneficiaries in traditional Medicare to choose to enroll in an Accountable Care Organization (ACO) and select

→ABSTRACT The CHRONIC Care Act expands access to primary care and homecare for Medicare beneficiaries with multiple chronic conditions, and extends Medicare's focus beyond medical treatment toward home support for people with chronic conditions. The Act includes a targeted, non-medical Medicare Advantage supplemental benefit option that is a test case for offering long-term services and supports–type benefits in Medicare. More needs to be done to build on the opportunities created by the Act to address unmet needs, especially functional assistance needs, of people with chronic conditions.

| **key words**: *CHRONIC Care Act, Medicare, Medicare Advantage, chronic conditions*

a primary care provider (PCP), and for the ACO to provide incentives for members to obtain necessary primary care services; and

√ Bringing primary care to the home through an expansion of Independence at Home and telehealth connections with PCPs.

The most significant driver of medical utilization is not just the medical needs of beneficiaries with multiple chronic conditions, but also the functional limitations for which many of them need assistance to get through the day. People with multiple chronic conditions and functional limitations have twice the annual Medicare spending of people with multiple chronic conditions and no functional limitations (Tumlinson, 2018).

Today, most of the funding for LTSS for people with substantial functional assistance needs comes through the Medicaid program. Many people with functional needs are either Medicaid-eligible or spend down to Medicaid eligibility. An equal number are Medicare beneficiaries who pay out-of-pocket due to having resources that make them ineligible for Medicaid.

The Act should improve access to primary care, and expand opportunities for in-home supports and services.

The other major focus of the Act is to encourage an expansion of opportunities for Medicare beneficiaries with functional limitations to have coverage for LTSS needed to remain in their homes and communities and avoid unnecessary emergency room visits, hospitalizations, and nursing home admissions. It does this through:

√ An expansion of Medicare Advantage (MA) Special Needs Plan (SNP) models for dual eligible beneficiaries that integrate Medicaid-covered LTSS with Medicare coverage and greatly improve care coordination and care management;

√ A new opportunity for MA plans to offer special supplemental benefits in Medicare that can provide specific non-medical services and supports targeted to people with specific chronic conditions; and

√ An expanded opportunity for MA plans through value-based insurance design to provide services and supports that are shown to reduce unnecessary medical utilization and result in better outcomes for the individual.

Importance and Impact of the CHRONIC Care Act

The greatest challenge for our healthcare system over the next few decades will be to meet the healthcare needs of a much older population without greatly expanding our institutional and highly specialized medical infrastructure and the outsized medical expenditures that go with it.

Only when we aggressively create options to divert medical spending into more non-medical services and supports to help maintain people with complex care needs in their homes and communities will we see a big improvement both in outcomes and reduction of avoidable medical utilization. Such options are necessary for the nation's growing aging population, and to do so without incurring major increases in medical infrastructure, personnel, and expenditures.

A major driver of medical costs are unmet and poorly met needs that many people with severe chronic conditions have for assistance with fundamental and basic daily tasks. Failing to provide this support system is a primary cause of older adults' poor health and excessive medical utilization. We must shift our resources to build the capacity to support people where they live.

The CHRONIC Care Act is, most importantly, a recognition and acceptance by Congress of this challenge. It is a Medicare bill that expands the focus of Medicare beyond "medical treatment only" and helps shift the center of gravity for people with chronic conditions toward the home and away from the revolving door of expensive, episodic, institutional care.

It is a small step in the direction of home-based care, but it is an important first step.

A significant component of this shift is the targeted, non-medical MA supplemental benefit option established by the Act that serves as a test case for offering LTSS-type benefits in Medicare. Initially, the benefits CMS allows plans to offer are likely to be limited and tentative. Congress and CMS have a long way to go before they allow MA plans the flexibility to fit to an individual with complex conditions those specific non-medical services and supports he or she needs to remain independent and at home.

Another important consequence of the Act is that it moves the ball forward on achieving true integration of Medicare and Medicaid benefits for people who are covered in both programs (known as dual eligibles). There is no good reason for carving up coverage for Medicare beneficiaries who receive Medicaid benefits. All people with dual eligibility should have their coverage through fully integrated plans that operate for the enrollee as if it were a single plan—today only 12 percent of duals are enrolled in integrated plans (Lester and Chelminsky, 2018).

'We need to shift our resources to build the capacity to support people where they are.'

The CHRONIC Care Act begins to expand availability of integrated plans in states that have Medicaid Managed LTSS (MLTSS). Half of the states, however, do not have MLTSS. In states that do have MLTSS and make integrated plans available, the majority of dual eligible beneficiaries in the state are not enrolled in integrated plans. Thus, much more needs to be done to educate beneficiaries about and enroll them in these plans.

Finally, the Act expands opportunities to bring a level of primary care into the home, through telehealth and the Independence at Home model, to provide a stronger link to primary and preventive medical care for people with the most complex care needs. Again, these provisions help open the door to the possibilities, but at nowhere near the scale to make home- and community-based care a viable alternative to avoidable emergency room, hospital, and nursing home admissions.

A Focus For the Future

If we are to succeed in making home- and community-based care a viable alternative for a large proportion of beneficiaries with chronic conditions, we need:

More investment in technology and care transformation. We must encourage the creation and adoption of technologies that improve connectivity between individuals with chronic conditions, their caregivers in the home, and their care teams. These include telehealth and other monitoring and communication technologies. We also need to develop and apply technologies that can help transform the care process for in-home care—to improve efficiency, expand the capabilities and responsibilities of the in-home workforce, empower caregivers, and make in-home care more affordable and practical as an alternative to institutional care for people with complex care needs.

Expansion of integrated care for dual eligibles. We must authorize and encourage states that have integrated care available to require dual beneficiaries to select and enroll in the integrated plan of their choice. At the same time, we need to drive transformation to a person-centered system that is accountable for quality and outcomes. We also should do more to encourage plans to attract, specialize in, and improve outcomes for beneficiaries with complex care needs.

Development of MA-only models that incorporate non-medical supports and services. For beneficiaries without Medicaid (and to avert Medicaid spend-down), we need to incorporate non-medical supports and services in the core package of MA-plan benefits—giving providers the flexibility to include in individual care plans the services and supports that can reduce avoidable hospital and institutional care.

Greater emphasis on primary and preventive care in the home. We must expand upon the redirection of medical resources to primary and preventive care in the home setting for people with chronic conditions to minimize the development of more complex care needs and reduce the use of specialized and institutional medical care.

Redesign of Medicare prescription drug coverage for chronic conditions. We need to design a benefit that ensures consistent and continuous drug coverage and lessens out-of-pocket exposure for beneficiaries with long-term drug regimens. Newly launched prescription drugs should be priced to value, taking into account patients' achieved outcomes. Greater effort should be focused on increasing medication adherence to improve outcomes and the overall value of drug treatment.

Conclusion

The CHRONIC Care Act marks the start of an important shift in congressional aims and health system orientation for the population most dependent upon, and most costly to, the Medicare program and the health system as a whole. With this Act, the Congress begins to move federal investment toward building home- and community-based support for individuals with chronic conditions and complex care needs.

The Act is a toe-in-the-water. It puts in place new, and potentially significant, Medicare initiatives to improve care for those who are covered by Medicaid and for people with similar needs who possess resources too substantial to qualify for Medicaid.

The unifying feature in these initiatives is their focus on preventing medical events and improving outcomes for individuals with multiple chronic conditions. But, as we know, it is not just about treating health conditions: it is as much a matter of assisting with activities necessary for daily functioning and ensuring individuals with chronic conditions can remain in their homes and communities for as long as possible.

In-home care needs to become more affordable and practical as an alternative to institutional care.

These new initiatives show promise for improving outcomes and afford an opportunity to test new approaches that could be scaled in the future to address much larger and more challenging unmet needs for LTSS financing.

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References

Bipartisan Policy Center. 2018. "Improving Care and Lowering Costs for Chronic Care Beneficiaries: Implementing the Bipartisan Budget Act." tinyurl.com/y8sse6ng. Retrieved November 29, 2018.

Lester, R. S., and Chelminsky, D. 2018. "Using CMS Data to Understand D-SNP Market Trends and Performance, Dual Eligible Characteristics, and State Medicaid Managed Care Programs." Slide presentation by Mathematica Policy Research to the 2018 SNP Alliance Executive Roundtable, Washington, D.C., March 27.

Tumlinson. A. 2018. "Functional Impairment a Key Factor in High Medical Spending." Anne Tumlinson Innovations. tinyurl.com/y7bsxmov. Retrieved December 13, 2018.

Partners in Care Foundation: A Change Agent in Community-Based Care

By June Simmons and Sandy Atkins

Impacts and outcomes of integrating social services with healthcare.

Twenty years ago, Partners in Care Foundation (Partners) was founded as a nonprofit community-based organization (CBO) with the tagline: "Changing the shape of healthcare." Its mission still reflects this goal: "Partners shapes the evolving health system by developing and spreading high value models of community-based care and self-management for diverse populations with chronic conditions. This focus differentiates Partners from many others in the field—the primary purpose of Partners is not to be a provider, but rather to be a change agent."

This unique mission and purpose may help explain why Partners has been at the forefront of the effort to build contracted relationships between community-based organizations and healthcare entities. This effort has not been easy, by any means, but the Partners board and its organizational structure were designed specifically to facilitate the integration of social services with healthcare. For example, the board has supported innovation and risk-taking because those elements are baked into Partners' purpose.

Also, leaders in top management at Partners were chosen for their backgrounds spanning healthcare and social services—hospital social work, nursing and retirement home administration, and adult day health center management. Another element that contributed to its readiness for healthcare contracting is Partners' genesis in a healthcare provider organization—the Visiting Nurse Association of Los Angeles.

Partners' Achievements

So what have this unique purpose, structure, and history enabled Partners to accomplish in the realms of service coordination and self-management support for people with multiple chronic conditions?

Partners now has contracts with the following organizations: two health systems (Providence Health and Services and UCLA Health), which involve eight hospitals; one commercial health plan (Blue Shield of California; all lines of business); two Medicare Advantage plans (UCLA Health, Blue Shield); six Medicaid plans (L.A. Care, Care1st, Molina, Health Net, Anthem,

➜ABSTRACT Partners in Care Foundation has built a close and successful collaboration with UCLA Health across a span of more than seven years. Results have been powerful, benefiting thousands of older adults. The contract has stood the test of time and has expanded over the years. Of crucial importance is the use of the HomeMeds intervention under the leadership of UCLA's MYMEDS pharmacists, who collaborate with the health system's medical providers. | **key words**: *ihealth systems, medications, care transitions, readmissions*

Kaiser); two Cal MediConnect (dual eligible) plans (L.A. Care, Health Net); and one Accountable Care Organization (ACO) (UCLA Health).

The services involved are varied, but include the following: health risk assessments; adult day health eligibility determinations; care transitions from hospital or skilled nursing facility back to home; Partners' HomeMeds program and in-home psychosocial, environmental, cognitive, and functional assessments; short- and long-term-care/service coordination; and self-management support.

These interventions all address individual-level social and behavioral determinants of health, and include caregiver support, provision of nutritious meals, knowledge for self-care, medication adherence support, transportation, and access to benefits.

'These interventions all address individual-level social and behavioral determinants of health.'

Examples of Working Partnerships

UCLA Health is the partner with which Partners has the longest and deepest relationship—it has lasted for more than seven years. Relationships built over decades resulted in UCLA Health engaging Partners to support its strategic plan on community services. In addition, Partners' CEO (co-author June Simmons) was invited to participate in UCLA Health's primary care redesign team.

Together with UCLA Health, Partners applied for and won a Centers for Medicare & Medicaid Services (CMS) Community-based Care Transitions Program (CCTP) contract to reduce fee-for-service Medicare readmissions. The process of preparing that application, which included an in-depth root-cause analysis of readmissions, built multi-level relationships between UCLA's and Partners' staff and leaders, from the chief medical officer to primary care case managers.

Operating the program further cemented relationships as Partners' staff worked to refine referral processes and coordinate care with UCLA social workers, nurses, pharmacists, and primary care physicians. The success of the CCTP led to a contract with the medical group to address readmissions in UCLA Health's Medicare Advantage and ACO populations.

Measuring Impacts and Analyzing Outcomes

UCLA has been an excellent partner, especially in terms of how it has measured the impact of the collaboration. Two post-acute interventions have been used and the results of both have been outstanding.

The first was the CMS-funded CCTP, through which Partners and UCLA worked together from 2013 to 2017. According to CMS (Econometrica, Inc., and Mathematica, 2017), "30-day post-discharge Part A and Part B expenditures were 17.30 percent (p<0.01) lower among participants than for matched comparisons. After accounting for this site's average PEDR [per-eligible discharge rate], this translated into lower net differences in Medicare Part A and Part B expenditures of $10,771,936 (p<0.01) between participants and matched comparisons."

A recent UCLA study (pending publication) did a propensity score matched analysis and found significant improvements in 30-, 60-, and 90-day readmissions and emergency department use. The interventions were the Coleman Care Transitions Intervention (a home-based health coaching model; tinyurl.com/ycxt7em7), and the Rush University Medical Center's The Bridge Model (telephonic social work; tinyurl.com/y9tvgdl4), plus Partner's medication safety intervention, HomeMeds.

HomeMeds involves a comprehensive in-home inventory of all medications, including over-the-counter medications and supplements; use of a computerized, evidence-based risk-screening tool; and pharmacist review and recommendations to patient and prescribers (AHRQ Innovation Exchange, 2010), and uses a UCLA

Health MYMEDS (tinyurl.com/y9lwpsx8) pharmacist to review and make recommendations to improve the medication regimen. Allowing for a choice of a home visit or telephonic intervention substantially increased the programs' geographic reach and overall uptake.

'UCLA has been an excellent partner in measuring the impact of the collaboration.'

The second, HomeMeds*Plus* (tinyurl.com/y9sfovtj), includes HomeMeds, plus an in-home psychosocial, fall-risk, and functional assessment with thirty or more days of follow through to identify and address unmet behavioral health and socioeconomic needs. The intervention is delivered by at least a bachelor's-degree-level human services professional, a social worker or health coach, and a pharmacist, who addresses medication issues.

According to UCLA, the post-acute HomeMeds*Plus* intervention, which included UCLA's MYMEDS pharmacists, decreased the overall readmission rate for the total high-risk population from 31.3 percent to 26.9 percent (net of the 1.4 percent decrease in readmissions experienced by the low-risk population). Compared to high-risk patients who did not receive the intervention, UCLA Health found that HomeMeds*Plus* achieved a dramatic 66 percent relative decrease in the readmission rate—from 31.3 percent to 10.6 percent. The population consisted of UCLA medical group's ACO and Medicare Advantage plan members and primary care patients. This paid contract involves about 300 patients a year.

Partners' other contracts also are excellent examples for CBO–healthcare partnerships, serving thousands of individuals each year with effective evidence-based care coordination and self-management models. These contracts continue to grow and prosper after three or more years, and even incorporate reimbursement increases to address geographic issues for our Partners at Home Network, related to staff traveling extreme distances in some of the largest counties in the United States.

Thus far, however, only UCLA has shared its outcomes. Lack of outcomes data from otherwise thriving healthcare contracts is a widely acknowledged barrier for CBOs in this new collaborative model. Typically, this is because there has been so much change in the information technology and security requirements for healthcare entities that their technical departments are unable to meet the demand for data reports beyond those mandated for regulatory or accreditation compliance.

Moving Forward Sustainably

Building on these successes, Partners continues pursuing new contracted relationships with other physician groups, health systems, and managed care organizations, under both Medicaid and Medicare payment. There is new federal flexibility to use Medicare Advantage revenue to address social determinants of health and growing success of some ACO and bundled payment models, and managed long-term-care services and supports for dual eligibles. These and the new broadening of Medicare fee-for-service physician billing codes all present opportunities for healthcare entities to use new revenue streams to pay for these powerful interventions.

Partners continues pursuing new contracted relationships with physician groups, health systems, and MCOs.

The W.M. Keck Foundation, recognizing the promise of the changing care environment, has provided Partners in Care with a major grant to support model development. The work focuses on the use of expanded Chronic Care Management Medicare physician billing codes to support integration of medical and social services for people with chronic illnesses.

These successes and the abundance of new care delivery opportunities argue strongly for broadening the healthcare team to include CBOs, and to use health coaches and pharmacists to address individual-level social and behavioral determinants of health and improve medication safety. By adopting these evidence-based and proven models, CBOs, in collaboration with pharmacists, healthcare providers, and payers, can finally, and sustainably, move forward and jointly provide true person-centered care to Medicare and Medicaid beneficiaries having multiple chronic conditions.

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References

AHRQ Innovation Exchange. 2010. "Care Managers Use Software-aided Medication Review Protocol for Frail, Community-dwelling Seniors, Leading to More Appropriate Medication Use." tinyurl.com/yays2ntu. Retrieved October 18, 2018.

Econometrica, Inc., and Mathematica Policy Research. 2017. *Final Evaluation Report. Evaluation of the Community-based Care Transitions Program*. tinyurl.com/yayy686n. Retrieved October 18, 2018.

Successful Chronic Disease Programming: The Important Role of Community Health Workers

By Carl H. Rush

> CHWs can help people achieve health equity, improve their clinical outcomes, and reduce the community-wide burden of chronic disease.

Integrating community health workers (CHW) into public health and healthcare programs and services has become more common in recent years, and is now a recognized strategy for payers and providers to achieve health equity, improve clinical outcomes, and reduce the personal and financial burden of chronic conditions. Findings in this area show there are expanding opportunities for CHWs to serve the health needs of America's aging population (Rush, 2015). This article profiles three promising models that illustrate a range of successful approaches to CHW integration in the domain of chronic disease.

Definition and Role of the Community Health Worker

The American Public Health Association (2018) defines a CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

For ten or more years, researchers have noted growing CHW roles in chronic disease prevention and management for poverty populations and communities of color (Bodenheimer, Chen, and Bennett, 2009; Shah, Kaselitz, and Heisler, 2013). As early as 2003, the American Association of Diabetes Educators (AADE) concluded that CHWs "play a unique, important role in the care and support of people with and at risk for diabetes within their communities; . . . [and CHWs should] teach diabetes educators and other healthcare team members about community needs . . ." (AADE, 2003).

➔ABSTRACT Integrating community health workers into public health and healthcare programs and services is a recognized strategy to achieve health equity, improve clinical outcomes, and reduce the personal and financial burden of chronic conditions. This article profiles three promising models illustrating a range of approaches to such integration in the domain of chronic disease: an ongoing effort in a regional healthcare provider system; a state policy taskforce associated with a statewide demonstration of Accountable Health Communities; and a culturally specific health promotion research project. | **key words**: *community health workers, Spectrum Health, Washington Community Health Worker Task Force, Healthy Fit Initiative*

More recently, in a series of systematic reviews (2015–2017), the Centers for Disease Control and Prevention (CDC) Community Preventive Services Task Force (CPSTF) recommended "interventions that engage community health workers" for cost-effective prevention and management of diabetes and cardiovascular disease (CDC/CPSTF, 2015, 2016, 2017).

And beginning in 2017, the American Diabetes Association (ADA), under the heading "Tailoring Treatment To Reduce Disparities," recommended that "patients should be provided with self-management support from . . . community health workers when available. . . . There is growing evidence for the role of community health workers . . . in providing ongoing support" (ADA, 2017).

> ***CHWs should teach diabetes educators and other healthcare team members about community needs.***

CHWs' contributions, challenges in managing chronic disease

Even with the best available clinical care, successful chronic disease management depends upon patient engagement, adherence to treatment and self-care regimens, and recognition of the social determinants of health. CHWs have proven adept at addressing these areas through peer relationships based on shared life experience (Gustafson, Atkins, and Rusch, 2018). CHWs successfully assist individuals in setting goals and provide social support to help maintain their self-care plans (Kangovi et al., 2017). In chronic disease management, as in other domains, CHWs can contribute significantly to controlling care costs, as was recently concluded in the Center for Medicare and Medicaid Innovation's Health Care Innovation Awards program (Bir et al., 2018).

Despite the appeal of CHWs, these workers are not widely accepted in the mainstream of public health and healthcare due to uncertainties of state and federal policy and a lack of general understanding about the nature of this workforce. As of this writing, only ten states had formal standards and definitions of CHW practice and skill requirements, as codified in programs of voluntary certification of CHWs (National Academy for State Health Policy [NASHP], 2018). Most CHW employment is still financed through short-term grants and contracts, although some states have included CHWs in Medicaid transformation through mechanisms such as Medicaid Section 1115 waivers and Health Homes State Plan Amendments (Association of State and Territorial Health Officers, 2016; NASHP, 2018).

Three Promising Innovations in CHW Integration

Profiled below are three leading CHW initiatives related to chronic disease: the first is an ongoing effort in a regional healthcare provider system; the second is part of a statewide demonstration of Accountable Health Communities; and the third is part of a culturally specific research project (each description is based on a summary of the cited reference).

Spectrum Health, Grand Rapids, Michigan

Spectrum Health (Larson, 2016), a nonprofit healthcare system, has employed CHWs for "many years," including Healthy Start services under contract with the state health department, but over the past five years, Spectrum has ramped up efforts to document CHW impact on chronic disease. Spectrum's CHWs cover a broad territory from their Grand Rapids, Michigan, base, following up on hospital discharges, monitoring indicators such as blood glucose, or offering self-management education.

Spectrum's Core Health program began in Grand Rapids hospitals and is now sustained with an annual operating fund, and is working to improve access and connect low-income and at-risk patients to community resources.

"These [CHWs as] individuals have faced challenges many of us take for granted, such as food insecurity, a lack of transportation, and poor housing," according to Kenneth Fawcett, M.D., vice president of Spectrum's Healthier Communities. "Because they are local, too, outreach workers tend to connect quickly with area residents," Fawcett adds. A number of CHWs are former Spectrum patients.

The Core Health program has produced impressive results in terms of improved health outcomes and a positive return on investment via reduced emergency department visits and inpatient admissions. And following a two-year pilot study (2013–2015), Core Health has expanded into rural Greenville and Lakeview, north of Grand Rapids. From an original focus on diabetes and cardiovascular disease, the program's focus has expanded to include asthma and chronic obstructive pulmonary disease (COPD).

Some CHWs have faced food insecurity, a lack of transportation, and poor housing.

In the rural study, patients receiving at least one CHW home visit per month "had fewer readmissions, lost weight, increased their activity level, improved their blood pressure and even had fewer dentist visits than before; appointment no-show rates have dropped. Total inpatient readmission charges for diabetes patients dropped by almost 39 percent, while inpatient readmission costs for heart failure patients fell by 9.5 percent, and readmission costs for those with both conditions dropped slightly more than 14 percent."

Lower inpatient readmissions alone reduced annual costs by almost half a million dollars. Spectrum has noted further intangible benefits from improved relationship quality with patients, and sees the initiative as central to the evolution of more person-centered care.

The rural program had a caseload averaging eighty to one hundred patients in 2016, around twenty-five per CHW; activities include setting and reinforcing the person's goals, and addressing social determinants of health, such as housing and food insecurity.

Spectrum attributes its success with CHWs to a deliberate change-management process involving all internal and community stakeholders, and notes that the rural hospitals' CHW efforts gained momentum when they became part of Spectrum and were able to leverage the resources and strategic vision of a large integrated system.

Spectrum also has been an active supporter of the Michigan CHW Alliance (MICHWA) since its inception in 2011 and, since 2003, has organized its own annual educational conference for CHWs. According to Program Manager Celeste Sánchez Lloyd, Spectrum has provided informal technical assistance to other employer organizations and contributed substantial in-kind staff support to developing MICHWA's standard CHW core training curriculum (in-person interview with Celeste Sánchez Lloyd, June 22, 2018).

Washington Community Health Worker Task Force, Seattle, Washington

A recent experience in Washington State illustrates the challenges of simultaneously introducing multiple policies when trying to transform healthcare. A statewide reform initiative, Accountable Communities of Health (ACH) (Spencer, 2018), incorporated a broader mandate to integrate CHWs. At the same time, state agencies engaged stakeholders in developing policies affecting the CHW workforce. Both initiatives called for engaging multiple parties in support of CHWs, and in such situations, role confusion can arise, especially when some parties have limited experience with CHWs.

ACHs extend the Accountable Care Organization concept by integrating a wide variety of community partners: housing agencies, school systems, law enforcement, etc., into efforts to address root causes of community health concerns. In Washington State's Medicaid Transformation Project Demonstration, nine ACHs are working to "address local health priorities, transform the Medicaid delivery system, improve population health, and reduce health care disparities" by addressing community systems capacity, as well as the healthcare delivery system (Spencer, 2018). All nine ACHs have chosen to focus in part on chronic disease prevention and control. Under Washington's Medicaid managed care contract (called Apple Health), CHWs can be part of a comprehensive care team and are allowed to provide services that facilitate the work of a care coordinator.

One culturally specific feature of Healthy Fit was the use of ***fotonovelas*** *as education tools.*

In line with the Washington State Healthcare Authority's "Healthier Washington" guidelines, all nine ACHs have included CHWs in order to achieve their project goals, including CHW roles in chronic disease–specific interventions. Six elected to work with the Foundation for Healthy Generations (Healthy Gen) on a CHW care coordination model called Pathways/Community Hub (tinyurl.com/ydyfe574). This approach was taken in part to address a lack of experience with CHWs among a number of the ACHs; replication of an existing, fully developed model was preferred to starting from scratch.

Parallel to the ACH initiative, the Washington State Health Care Authority and the Washington State Department of Health charged the Community Health Worker Task Force in 2015 with developing policy and system change recommendations to align with the Healthier Washington initiative. The task force's work was viewed as key to the long-term sustainability of programs such as the ACH initiative; Healthy Gen also played a pivotal role in the task force's work. In February 2016, the task force released a set of recommendations, which included defining CHW roles, skill requirements, training standards, and financial sustainability. It did not, however, produce concrete recommendations related to state-level certification of CHWs.

Due to the pace of the task force work and the prominence of Healthy Gen and the ACHs in its deliberations, a number of stakeholder groups, notably in rural areas, expressed reservations about the task force process and its conclusions; for a variety of reasons, the task force process suffered a major loss of momentum after release of the recommendations.

In January 2018, building off the task force recommendations, the state legislature passed a bill to support refining earlier task force recommendations and producing a plan of action (per telephone interviews with Scott Carlson, Washington State Department of Health, Kathy Burgoyne, Foundation for Healthy Generations, and Seth Doyle, Northwest Regional Primary Care Association, for the Association of State and Territorial Health Officials, May–August 2018).

Healthy Fit Initiative, El Paso, Texas

The Healthy Fit initiative was a pilot project developed as a partnership between the local health department and the University of Texas School of Public Health (El Paso campus), with funding from a Medicaid Section 1115 waiver and additional support from a National Cancer Institute Community Networks Program grant (Brown et al., 2018). The purpose of 1115 waivers is to demonstrate innovations in care delivery, which can be implemented more widely to improve outcomes and control costs under Medicaid. A number of states have included CHW interventions as part of 1115 waivers.

Although the Healthy Fit study was not specifically focused on older adults, the percentage of the study sample who were eligible for colorectal cancer screening (39 percent) and-or breast cancer screening (38 percent of women) suggests that the project reached a substantial number of adults ages 50 and older.

While the Healthy Fit approach was somewhat conventional in terms of CHW roles, it shows how these roles can be culturally adapted in specific settings. The CHWs in Healthy Fit were known as *promotores de salud*, a common title in Hispanic/Latino communities. But the history of *promotores* in the United States and in Latin America shows an emphasis on "community transformation," an empowerment model driven by a community's internal priorities and resources rather than the goals of healthcare institutions (Visión y Compromiso, 2016). *Promotores* fall under the umbrella term of CHW because they derive their effectiveness and much of their value system from lived experience, which they share with the community they serve.

In the case of Healthy Fit, the *promotores* were not operating under a true community transformation model, but were engaged in recruitment, health education, referral to community resources, and social support for lifestyle changes aimed at improving health status. They had latitude to design word-of-mouth recruitment and telephone follow-up in ways that would be considered acceptable to local community norms, which include elements of Mexican-origin culture, but are specific to the local community. This tailored aspect of "cultural humility" is a strength of CHWs with locally rooted experience; knowledge of the fundamentals of Mexican culture does not guarantee success in specific communities.

One culturally specific feature of Healthy Fit was the use of *fotonovelas,* which typically are short graphic novels with photos rather than illustrations, as education tools. The Healthy Fit *fotonovelas* were used to send positive messages or cautionary tales on health issues, with characters who physically resembled community members. The CDC recommends and has produced *fotonovelas* for educational strategies with Hispanic-Latino communities (CDC, 2015).

In addition to its emphasis on physical activity to prevent and reduce obesity as a contributing factor in diabetes and cardiovascular disease, Healthy Fit also encouraged routine screening for various forms of cancer, and achieved increases in screening rates for the study participants. Of those found to be "behind" in scheduling recommended screenings for breast, cervical, and colon cancers, 45 percent, 32 percent, and 20 percent, respectively, received recommended screenings as a result of the *promotores'* intervention (Brown et al., 2018).

The *promotores'* cultural awareness and relationship capabilities were likely crucial in this aspect of the project, because many in such populations are reluctant to be screened due to established belief systems, some of them culturally based. Such belief systems include fatalism, faith-based practices, and a mistrust of healthcare institutions. For this project, special arrangements also were often necessary to provide access to clinical services needed by large numbers (80 percent) of uninsured or underinsured participants (in many cases this was due to these participants' undocumented status). These specific arrangements included vouchers for free services provided by the local health department.

Analysis

These three initiatives all are successful on some level, and provide examples of the broad range of CHW activities related to chronic disease. Spectrum Health is an example of a long-standing commitment to CHWs as a responsive approach to community needs. Spectrum executives credit the "high-touch" approach of CHWs—enabled by their embeddedness in the community—with achieving advances in patient self-management and adherence to treatment, as well as amelioration of patient stress associated with social determinants of health.

Spectrum's commitment has gone beyond inclusion of CHWs in externally funded positions to integrating some CHW staff into the system's core budget (twenty-seven positions in summer 2018) and to leadership in statewide policy and standardization of the workforce across employers and programs (per in-person interview with Celeste Sánchez Lloyd, June 22, 2018).

The Washington State experience illustrates the potential for CHW inclusion and sustainability in chronic disease prevention and management resulting from the interest of managed care organizations and new structures that emphasize care coordination, and from addressing the social determinants of health. It also reflects, however, the need for due deliberation and adequate time for inclusive design processes, particularly efforts to include leadership from a broad spectrum of CHW backgrounds and practice settings. Especially when considering CHW credentialing (certification), the process requires a full airing of aspirations, fears, and preconceptions about the nature of certification and its impact, especially among stakeholders who may have limited understanding of the true nature of CHW practice.

Healthy Fit represents a large number of grant-funded pilots and demonstrations involving CHWs in management of chronic disease. It clearly illustrates the importance of CHW engagement in designing culturally responsive approaches to prevention and self-management support. Dozens, if not hundreds, of such projects have shown promising results, but either have not been included in meta-analyses or systematic reviews (sometimes due to study limitations, but often because such research projects do not use metrics that are comparable to those in other studies). Further efforts are needed to arrive at common metrics that can facilitate pooling or comparison of research data.

Managed care organizations are scrutinizing CHW initiatives such as these with a view to increasing the robustness of community-level prevention, improving continuity and coordination of care, and emphasizing chronic conditions, which absorb increasing amounts of healthcare resources. Despite a growing body of evidence nationally, stakeholders at the state and local levels often insist upon seeing localized results from CHW interventions to be assured that these interventions will work in their specific communities. Similarly, workforce development for CHWs depends on public policies that are adapted to local realities and created with CHWs' active participation.

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References

American Association of Diabetes Educators. 2003. "Position Statement: Diabetes Community Health Workers." *The Diabetes Educator* 29(5): 818–24.

American Diabetes Association. 2017. "Standards of Medical Care in Diabetes 2017." *Diabetes Care* 40(Suppl 1): S1–2.

American Public Health Association. 2018. "Community Health Workers." tinyurl.com/ybrsk95n. Retrieved November 5, 2018.

Association of State and Territorial Health Officers. 2016. "Community Health Worker Certification and Financing." Issue Brief. tinyurl.com/ydhtjsxh. Retrieved October 13, 2018.

Bir, A., et al. 2018. *Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative*. Annual Report Year 3. Research Triangle Park, NC: RTI International.

Bodenheimer, T., Chen, E., and Bennett, H. D. 2009. "Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job?" *Health Affairs* 28(1): 64–74.

Brown, L. D., et al. 2018. "Evaluation of Healthy Fit: A Community Health Worker Model to Address Hispanic Health Disparities." *Preventing Chronic Disease* 15(E49): 1–11.

Centers for Disease Control and Prevention (CDC). 2015. *Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-Level Approach* (2nd ed.). Atlanta, GA: CDC.

CDC, Community Preventive Services Task Force (CPSTF). 2015. “Cardiovascular Disease: Interventions Engaging Community Health Workers.” tinyurl.com/y7zpujvp. Retrieved October 12, 2018.

CDC/CPSTF. 2016. “Diabetes Prevention: Interventions Engaging Community Health Workers.” tinyurl.com/y7rq27vn. Retrieved October 12, 2018.

CDC/CPSTF. 2017. “Diabetes Management: Interventions Engaging Community Health Workers.” Atlanta, GA: CDC. tinyurl.com/yakgl46e. Retrieved October 12, 2018.

Gustafson, E. L., Atkins, M., and Rusch, D. 2018. “Community Health Workers and Social Proximity: Implementation of a Parenting Program in Urban Poverty.” *American Journal of Community Psychology* (Epub ahead of print). doi: 10.1002/ajcp.12274.

Kangovi, S., et al. 2017. “Community Health Worker Support for Disadvantaged Patients with Multiple Chronic Diseases: A Randomized Clinical Trial.” *American Journal of Public Health* 107(10): 1660–7.

Larson, L. 2016. “How Community Health Workers Can Improve Patient Outcomes: Community Health Worker Program Records Quantifiable Gains for Patients, System.” Chicago: Hospital and Health Networks. tinyurl.com/y9ux6rmd. Retrieved November 5, 2018.

National Academy for State Health Policy. “State Community Health Worker Models.” tinyurl.com/y9mj5fc9. Retrieved October 13, 2018.

Rush, C. H. 2015. “Community Health Workers Moving to New Roles as More Seek to Age in Place.” tinyurl.com/ybtc7tmd. Retrieved October 13, 2018.

Shah, M., Kaselitz, E., and Heisler, M. 2013. “The Role of Community Health Workers in Diabetes: Update on Current Literature.” *Current Diabetes Reports* 13(2): 163–71.

Spencer, A. 2018. *Integrating Community Health Workers into State and Local Chronic Disease Prevention Efforts: Program and Financing Considerations*. Washington, DC: Academy Health.

Visión y Compromiso. 2016. *California Perspectives on Workforce Development and the Promotore Model for Community Transformation*. Los Angeles: Vision y Compromiso.

Healthcare Providers Can Help to Connect Family Caregivers to Resources and Supports

By Donna Benton and
Kylie Meyer

> Services cannot truly "wrap around" care recipients unless caregivers are brought into the loop.

When his wife, Helen, was diagnosed with Alzheimer's disease a year ago, Gary promised to "be her memory." Their children, scattered across the country, suggested their parents should move to an assisted living community. But Gary told them, "We get by just fine!"

That changed suddenly when Helen slipped in her sock-clad feet, fell, and broke her hip. When she returned home from the hospital, Gary became overwhelmed. Helen needed help showering, needed reminders to use her new walker, and assistance with changing her bandages. As there was no one else to look after Helen, Gary couldn't get a break to play cards with his friends anymore.

When his daughter called, Gary admitted, "I'm not sure I can take care of mom anymore at home. I'd ask your mom's doctor for help, but what can she do? Anyway, the last time I spoke to her, she just told me I was a great husband. Now, my doctor told me my blood pressure is bad and I should exercise more. How am I going to do that? (Note: This is a fictionalized case, meant to highlight issues frequently encountered by family caregivers.)

The foundational role of family caregivers to the U.S. long-term supports and services (LTSS) system cannot be overstated. Caregivers like Gary annually contribute an estimated $470 billion worth of support, and make it possible for people with an illness or disability to remain members of their communities (Reinhard et al., 2015). At any one time, 17.7 million Americans provide informal care to an older family member, including families of choice, or a friend (Schulz et al., 2016).

The demands placed on caregivers today are unlike those experienced by previous cohorts of caregivers. Today's caregivers attend to a population of older adults who are reaching more advanced ages, but who are not necessarily in good health (Crimmins and Beltrán-Sánchez,

➔ABSTRACT Family caregivers today face new and challenging caregiving demands. Community-based resources can reduce risks to caregivers' health and well-being, but are limited by low funding levels. Healthcare providers can step in to support caregivers by administering person- and family-centered care. This article encourages healthcare providers to engage family members during appointments where appropriate; respect that caregivers may not be willing or able to provide care; screen for caregiver needs, capacity, and willingness to provide care; and advocate for reimbursement codes for caregiver supports and services through Medicare and Medicaid. | **key words**: *family caregiving, community-based organizations, care transitions*

2011). Consequently, Gary, a man in his 70s, can expect to spend about a year and four months of his remaining life providing care (Schulz et al., 2016).

And while breakthroughs in medical knowledge, interventions, and technologies have served to extend life and improve its quality for individuals with an illness or disability, these changes also have meant that caregivers are now managing more complex types of care—often for someone having multiple conditions. Wound care and medication management are just some of the tasks family members take on. Many caregivers express discomfort with performing these tasks, and receive little training (Reinhard, Levine, and Samis, 2012).

The demographics of the caregiver population also are changing. Today, one in four caregivers are Millennials (Flinn, 2018). While women remain disproportionately represented among caregivers—approximately 60 percent of caregivers are women (National Alliance for Caregiving [NAC] and AARP Public Policy Institute [AARP], 2015)—this difference is less pronounced among Millennial caregivers. Also, younger cohorts of caregivers are more racially, ethnically, and culturally diverse than previous cohorts. And we are seeing more families balancing care for children with care for an older relative, and many family members are living far away from older adults who need care. Healthcare providers need to be aware of family members' limitations when being asked to provide care and support services.

Even when care is given from a place of love or compassion, caregiving takes a toll. Caregivers are at heightened risk of musculoskeletal injury compared to non-caregivers, due to performing tasks such as lifting the care recipient (Darragh et al., 2015). Spousal caregivers are prone to declines in cardiovascular outcomes (Monin et al., 2010). In particular, caregivers are at risk of psychological morbidities, including depression (Pinquart and Sörensen, 2003). Poor health among caregivers is attributed to both damaging health behaviors (e.g., poor nutrition) and the impacts of caregiver burden and stress (Adelman et al., 2014; Hoffman, Lee, and Mendez-Luck, 2012).

Given the growing number of older adults who will need care, and the restrictions on families' ability to provide care, it is projected that there will be fewer family caregivers to support the growing aging population (Schulz et al., 2016). Thus it is all the more critical to support families as they provide care and to reduce risks to their health and well-being.

Community-Based Supports for Family Caregivers

The negative consequences associated with caregiving are not inevitable, and there are programs whereby healthcare providers can refer caregivers to supports. Several interventions have been shown to reduce depression and other mental health morbidities that are common among caregivers (Schulz et al., 2016). Although effect sizes for these interventions are small to moderate, they are comparable to Food and Drug Administration–approved prescription medications for depression (Gitlin et al., 2015). Particularly promising are interventions administered at the time of diagnosis or during a care transition, when caregivers are adjusting to new demands. The National Family Caregiver Support Program (NFCSP) also funds community-based organizations to provide information and referrals, assess client needs, provide education and training, distribute respite care, and provide counseling services to caregivers.

Family caregivers make it possible for people with an illness or disability to remain members of their communities.

For Gary, NFCSP-funded programming could identify respite care options so he could take a break from caregiving and see his friends. Community-based programs also can serve as "eyes and ears" for healthcare providers.

Through service assessments and time spent with caregivers during programming, social service providers can identify red flags to caregivers' and care recipients' health and recommend follow up with healthcare providers.

There also are benefits to recipients when caregivers receive support. Interventions for caregivers have demonstrated the ability to delay a care recipient's placement in a nursing home (Foldes et al., 2017). Further, an older adult with a neurodegenerative disorder (e.g., Alzheimer's), who receives assistance from a caregiver with poor mental health experiences earlier mortality and is at a greater risk of experiencing elder mistreatment (Lwi et al., 2017; Wiglesworth et al., 2010). Intervening early in the caregiving process may be one way to prevent negative outcomes.

Still, community-based caregiver support programs are stretched for resources. Multisession psychoeducational programs—thought to be the most effective interventions—cost hundreds of dollars per dyad to administer. These services also must engage in extensive outreach to meet community needs. Many family members—especially those in the early stages of taking on the caregiver role—are more likely to think of themselves as "husband," "daughter," or "friend," and may overlook services targeted at "caregivers."

With an annual budget of just $126 million (Administration for Community Living, 2017), the National Family Caregiver Support Program is ill-equipped to robustly meet the needs of family caregivers who are caring for older adults. And while not all caregivers need formal services, changes in care recipients' health and caregiver turnover drive the need for support.

How Health Service Providers Can Meet Family Caregivers' Needs

In light of these challenges family caregivers face, in 2015 the California Legislature passed ACR 38 (California Taskforce on Family Caregiving, 2015) to create the California Taskforce on Family Caregiving; Taskforce members provided policy recommendations to better support the state's 4.5 million family caregivers (final recommendations were released in July 2018 and are available at tinyurl.com/y954w432). The following recommendations are based on those found in the Taskforce's final report and on our own experiences.

Screen early for caregivers' support needs, capacity, and willingness to provide care

Visits to healthcare settings often demarcate the beginning of or a significant change in the caregiving role, and are ideal places to identify and screen for a caregiver's support needs. In recent years, many state legislatures have acknowledged the important role health services can play in supporting family caregivers by passing versions of the Caregiver Advice, Recognize, Enable (CARE Act) legislation (Coleman, 2016). The law requires healthcare providers, in the hospital setting, to identify patients' caregivers and add caregivers to patients' health records.

'The negative consequences associated with caregiving are not inevitable.'

A benefit of this law is that by identifying family members as "caregivers," family members may be more willing to relate to the term "caregiver" and be better able to find community services intended for them.

Healthcare providers in hospitals can enhance the benefits of new and forthcoming CARE Act requirements by promoting implementation of a caregiver needs assessment when the caregiver is identified, and checking that the caregiver is willing and has the capacity to provide care. In doing so, at-risk caregivers can be discovered earlier so that appropriate supports can be implemented and-or alternative sources of care can be determined. In recent years, community organizations have compiled tools to assess at-risk caregivers. Notably, Alzheimer's Greater Los Angeles has compiled several screening tools and resources to help professionals support family caregivers (see tinyurl.com/yayrsrhd).

Advocate for Medicare and Medicaid reimbursement for caregiver services

Also recommended is that providers advocate for Medicare and Medicaid reimbursement for caregiver interventions and supports. Despite demonstrated benefits to care recipients, until recently, neither federal program extended reimbursement for caregiver support services. An exception to this is the recent addition of Medicare reimbursement code 99483. This billing code enables some health service providers to be reimbursed for identifying caregivers; assessing caregiver resources, support needs, and willingness to provide care; and medication reconciliation (Alzheimer's Association, 2018).

While the addition of this code is groundbreaking, its application remains limited. The code applies to caregivers to people with Alzheimer's disease and related dementias—a caregiver cohort representing only about a third of caregivers to individuals older than age 50 (NAC and AARP, 2015). It also does not provide reimbursement for high-intensity, multi-session caregiver interventions for family caregivers with high needs.

As telehealth options become more integrated into the healthcare system, healthcare providers should be aware of the potential of these tools to support family caregivers, and also encourage reimbursement for digital services. In 2016, the Family Caregiver Alliance (FCA) launched FCA CareJourney, a Web-based and assessment-driven online support tool for family caregivers (see www.caregiver.org). In addition to providing tailored resources for caregivers, the program serves as an "electronic health record" for caregivers' well-being and needs.

Involve relatives in appointments, with permission and where appropriate

Finally, healthcare providers should engage family caregivers within health settings. One way to do this is by asking a patient's permission for his or her trusted family member to be present during cognitive assessments. When this is done, it is important to ensure the relative is there to observe and not to answer questions for the person. What can emerge from this engagement is a health provider's new understanding, as communicated by a family member, of the person's strengths and challenges. For some family members, such engagement during an assessment may be the first time they fully realize their loved one has a cognitive impairment.

Some healthcare providers make themselves available to caregivers when the care recipient is not present. This can provide an opportunity for caregivers to openly share concerns about the care recipient and their own ability to provide care. At the same time, providers should be aware that some family members do not want to provide care, and should not assume the extent to which families can and are willing to provide assistance (Gershon and Carlson, 2018).

> ***'Healthcare providers should engage family caregivers in health settings.'***

Conclusion

Family caregivers are faced with new and changing demands, and often experience declines to their health and well-being while performing the caregiver role. Caregivers may be the foundation to the provision of long-term services and supports, but healthcare providers can lighten caregivers' loads through a commitment to person- and family-centered care.

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References

Adelman, R. D., et al. 2014. "Caregiver Burden: A Clinical Review." *Journal of the American Medical Association* 311(10): 1052–60.

Administration for Community Living. 2017. "Older Americans Act (OAA)." tinyurl.com/yadvqgyq. Retrieved November 5, 2018.

Alzheimer's Association. 2018. "CPT Code 99483: Explanatory Guide for Clinicians." Fact Sheet. tinyurl.com/yb4hggut. Retrieved November 5, 2018.

California Taskforce on Family Caregiving. 2015. ACR-38, Cal. Assemb.

Coleman, E. 2016. "Family Caregivers as Partners in Care Transitions: The Caregiver Advise Record and Enable Act." *Journal of Hospital Medicine* 11(12): 883–5.

Crimmins, E. M., and Beltrán-Sánchez, H. 2011. "Mortality and Morbidity Trends: Is There Compression of Morbidity?" *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 66(1): 75–86.

Darragh, A. R., et al. 2015. "Musculoskeletal Discomfort, Physical Demand, and Caregiving Activities in Informal Caregivers." *Journal of Applied Gerontology* 34(6): 734–60.

Flinn, B. 2018. *Millennials: The Emerging Generation of Family Caregivers*. Washington, DC: AARP Public Policy Institute. tinyurl.com/ybedy35c. Retrieved November 5, 2018.

Foldes, S. S., et al. 2017. "Medicaid Savings from The New York University Caregiver Intervention for Families with Dementia." *The Gerontologist* 58(2): e97–106.

Gershon, R., and Carlson, E. 2018. "Medicaid Enrollees Put at Risk When State Medicaid Programs Assume Support from Family Caregivers." Justice in Aging Issue Brief. tinyurl.com/y6wwtrm7. Retrieved November 5, 2018.

Gitlin, L. N., et al. 2015. "Translating Evidence-based Dementia Caregiving Interventions into Practice: State-of-the-science and Next Steps." *The Gerontologist* 55(2): 210–26.

Hoffman, G. J., Lee, J., and Mendez-Luck, C. A. 2012. "Health Behaviors Among Baby Boomer Informal Caregivers." *The Gerontologist* 52(2): 219–30.

Lwi, S. J., et al. 2017. "Poor Caregiver Mental Health Predicts Mortality of Patients with Neurodegenerative Disease." *Proceedings of the National Academy of Sciences* 114(28): 7319–24.

Monin, J. K., et al. 2010. "Spouses' Cardiovascular Reactivity to Their Partners' Suffering." *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 65(2): 195–201.

National Alliance for Caregiving and AARP Public Policy Institute. 2015. *Caregivers of Older Adults: A Focused Look at Those Caring for Someone Age 50+*. tinyurl.com/y8tw9aob. Retrieved November 5, 2018.

Pinquart, M., and Sörensen, S. 2003. "Differences Between Caregivers and Non-caregivers in Psychological Health and Physical Health: A Meta-analysis." *Psychology and Aging* 18(2): 250–67.

Reinhard, S. C., Levine, C., and Samis, S. 2012. *Home Alone: Family Caregivers Providing Complex Chronic Care*. Washington, DC: AARP Public Policy Institute. tinyurl.com/98z5g5o. Retrieved November 5, 2018.

Reinhard, S. C., et al. 2015. "Valuing the Invaluable: 2015 Update." *Insight on the Issues, 104*. tinyurl.com/q3pjaou. Retrieved November 5, 2018.

Schulz, R., et al. 2016. *Families Caring for an Aging America*. Washington, DC: National Academies of Sciences, Engineering, and Medicine, Committee on Family Caregiving for Older Adults.

Wiglesworth, A., et al. 2010. "Screening for Abuse and Neglect of People with Dementia." *Journal of the American Geriatrics Society* 58(3): 493–500.

How Will LTSS and Medical Care Integrate to Provide Community-Based Care?

By Anne Montgomery and Sarah Slocum

Expanding PACE to other beneficiaries in Michigan, and partnering with a healthcare plan in Indiana.

Some aspects of the future are impossible to predict, but some are entirely certain, and the upcoming growth of LTSS demand is quite clear. In 2017, spending on long-term services and supports (LTSS) reached $348 billion, a 48 percent increase from 2008, when spending was $235 billion (Open Minds, 2018). An estimated 12 million Americans receive LTSS every year—older adults, individuals with physical disabilities, people with intellectual and developmental disabilities, and others at risk of institutionalization—and, by mid-century, that number will rise to an estimated 27 million (Norman, 2013).

Managed care already is transforming the Medicaid LTSS market, with twenty-four states in 2017 reporting that they were using managed LTSS plans to serve primarily older adult populations and adults with physical disabilities (Lewis et al., 2018). But the more interesting—and less predictable—part of this story involves new types of partnerships and emerging service delivery arrangements that the integration of medical care and LTSS is starting to produce, and how these arrangements can benefit communities.

This article discusses two scenarios: contracting opportunities for Program of All-Inclusive Care for the Elderly (PACE) organizations that want to expand their footprint into the Fee-for-Service (FFS) Medicare-only market, a population that can pay for LTSS out-of-pocket; and evolving arrangements from partnerships between Area Agencies on Aging (AAA) and managed care organizations (MCO) that serve commercial and Medicaid populations—and which may expand over the next several years into serving Medicare Advantage (MA) plan enrollees.

MA Flexibility Can Mean Business Opportunities for PACE

Some PACE organizations are starting discussions about the types of possible arrangements

➔ABSTRACT The impending growth of long-term services and supports (LTSS) demand is clear. In 2017, LTSS spending reached $348 billion, a 48 percent increase from 2008. An estimated 12 million Americans receive LTSS every year, and that number will rise to an estimated 27 million by mid-century. Innovative plans and programs are emerging for older adults, a result of integrating LTSS into medical care. This article describes two community-based programs; one expands PACE to other beneficiaries, and another involves the aging network in integrated services arrangements with healthcare. | **key words**: *LTSS, PACE, CHRONIC Care Act, Medicare Advantage plans, Aging & In-Home Services*

with MA plans that could provide cost-effective, high-quality coordinated care for complex patients, including supplemental and supportive services. Both PACE and AAA providers are authorized to serve designated geographic areas, and as the number of older adults grows in communities across the country, they are well-positioned to expand to serve more of this population, in part through contractual partnerships with larger MA plans and other MCOs and healthcare organizations.

'Major MCOs are also taking a closer look at the PACE model.'

In 2018, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act ushered in a new era in LTSS for the Medicare program. CHRONIC was incorporated into the Balanced Budget Act of 2018 (BBA) and signed into law on February 9, 2018. Also in 2018, the Centers for Medicare & Medicaid Services (CMS) amended long-standing policy on supplemental benefits to enable MA plans to have greater flexibility in providing optional services that are clearly LTSS-focused (see sidebar, below).

MA plans now have an opportunity to consider how to improve the quality and efficiency of care for their most complex enrollees by offering targeted, cost-effective supplemental LTSS.

Major MCOs also are taking a closer look at the PACE model. PACE organizations are chartered to serve certain geographic areas, and they build PACE centers in the communities in which they are anchored. A core asset of the PACE interdisciplinary team is its ability to monitor and rapidly adapt services to changing needs of participants, who are mostly frail and disabled older adults. As a subset of Medicare beneficiaries become frail, these attributes may prove attractive to MA plans that will increasingly have members needing ongoing medical management and LTSS.

The Changing Policy on LTSS Supplemental Benefits

On April 27, 2018, CMS issued a groundbreaking memo addressed to MA plans and Section 1876 cost plans. Titled "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits," the memo states, "Organizations may decide to offer some items and services that may be appropriate for enrollees who have been diagnosed with needing assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)" (CMS, 2018a).

Subject to approval by CMS, for the first time, MA plans may offer supplemental benefits that include adult daycare services, home-based palliative care, in-home support services, limited support for enrollees' caregivers, medically approved non-opioid pain management, stand-alone memory fitness education, home and bathroom safety devices and modifications, and transportation to obtain "non-emergent" covered items and services and over-the-counter medications.

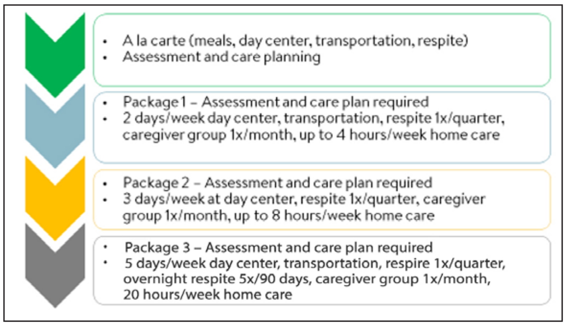
The agency's "Call Letter" for calendar year 2019 announced that MA plans would have additional flexibility in the bidding process with regard to the scope of "healthcare benefits" that are offered as supplemental benefits (CMS, 2018b). The letter explained, "Under our new interpretation, in order for a service or item to be 'primarily health related' under our three-part test for supplemental health care benefits, it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization." CMS noted, "This will allow MA plans more flexibility in designing and offering supplemental benefits that can enhance beneficiaries' quality of life and improve health outcomes."

In 2020, the Balanced Budget Act (BBA) statutory language allows supplemental benefits to be offered to enrollees with chronic conditions as long as they can demonstrate a "reasonable expectation of improving or maintaining . . . health or overall function" (BBA, 2018).

One large MA plan in the Northeast is discussing a pilot program to identify high-risk enrollees who would benefit from significantly more care coordination, complex case management, and LTSS supports than most MA enrollees need. These members would be referred to a PACE plan for some services, and PACE practitioners would coordinate with the individual's community healthcare providers.

In another example, in Ypsilanti, Michigan, the Huron Valley PACE (HVP), which opened four years ago, is pursuing strategies to expand and scale to serve FFS Medicare-only beneficiaries with LTSS needs. Toward that end and under the leadership of Executive Director Sonja Love Felton, HVP is developing supplemental LTSS services packages to offer to FFS Medicare-only beneficiaries. The three services packages (see Figure 1, above) are geared to varying needs, and include a baseline assessment. These packages also will inform discussions of possible LTSS services that could be offered to interested MA plans.

Figure 1. Huron Valley PACE Supplemental Services Packages Proposed for Private-Pay, Not-Enrolled, Clients



- A la carte (meals, day center, transportation, respite)
- Assessment and care planning

- Package 1 – Assessment and care plan required
- 2 days/week day center, transportation, respite 1x/quarter, caregiver group 1x/month, up to 4 hours/week home care

- Package 2 – Assessment and care plan required
- 3 days/week at day center, respite 1x/quarter, caregiver group 1x/month, up to 8 hours/week home care

- Package 3 – Assessment and care plan required
- 5 days/week day center, transportation, respite 1x/quarter, overnight respite 5x/90 days, caregiver group 1x/month, 20 hours/week home care

Development of the HVP supplemental services packages has experienced some challenges. To address these, HVP partnered with Altarum's Program to Improve Eldercare (tinyurl.com/ybn7kdb6). HVP and Altarum have identified the cost of prescription drug coverage as a major barrier in enrollment of FFS Medicare-only participants. Altarum is working to resolve these barriers for HVP and for other PACE plans, through PACE and Part D waivers presented to CMS. Also HVP and Altarum are exploring policy options for FFS Medicare-only beneficiaries whose incomes are slightly too high for enrollment in Medicaid, and who are unable to pay the full cost of needed LTSS.

Below are two figures illustrating how PACE organizations could partner with MA plans.

In Model Number 1, the PACE organization takes on comprehensive responsibility for Medicare-covered services, supplemental benefits, and supportive services for selected chronically ill enrollees referred by the MA plan. This MA plan would receive a capitation payment for each enrollee, but all health-related services (medical, supplemental, and supportive services) would be the responsibility of the PACE organization. The payment and risk-bearing terms would be negotiated and agreed upon in a contract. In this model, the MA plan collects the Medicare per member, per month payment, maintains the interface of reporting and regulatory compliance with Medicare, and performs other administrative functions, while the chronically ill Medicare beneficiary and his or her family view the PACE organization as their primary locus of care planning and service provision.

Figure 2. Model 1: PACE Responsible for Medicare-Covered Services

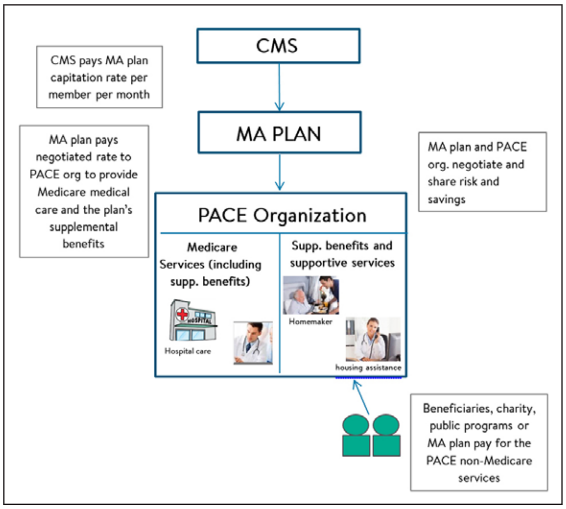
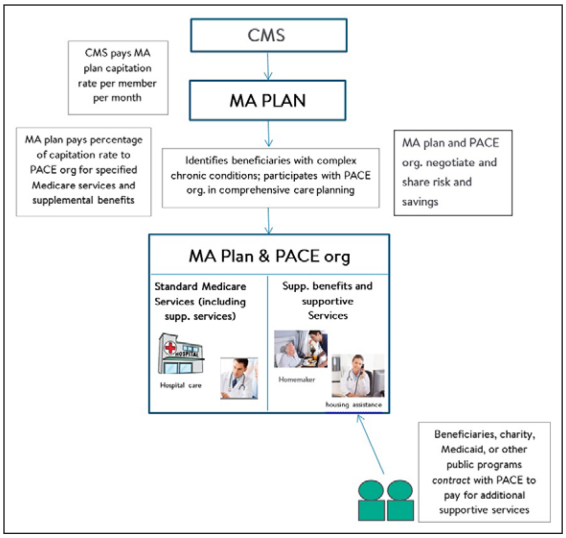


Figure 3. Model 2: MA Plan and PACE Both Provide Services



In Model Number 2, the MA plan and PACE organization both provide services, and the MA plan pays the PACE organization to provide a specific set of Medicare-covered services and supplemental benefits under contract. In this arrangement, some Medicare-covered services and supplemental benefits remain the responsibility of the MA plan, and some would be provided by the PACE organization. Supportive services that are not supplemental benefits in the MA plan would be the responsibility of the PACE organization, and their costs would be paid by the beneficiary, by a charity, by Medicaid, or by another public program.

Model Number 2 would most clearly fit a staff model MA plan that succeeds in providing customized care for Medicare beneficiaries living with advanced chronic illness. MA plan enrollees with chronic conditions would have the advantages of access to LTSS services at a PACE Center—services such as nutrition support, socialization, personal care and assistance, along with transportation, caregiver support, and extensive coordination of services and supports; parties would negotiate and contract for a shared financial and a shared clinical services arrangement. The MA plan and PACE organization also would establish an integrated care-planning team, and have shared access to interoperable records.

Community-Based Providers in Large Contracts with Managed Care Plans

In Fort Wayne, Indiana, Aging & In-Home Services (AIHS) of Northeastern Indiana, a leading AAA, is partnering with Preferred Population Health Management. AIHS has embraced a wide-angle vision of how the aging network can align its mission in the context of large-scale managed care delivery systems. Like other AAAs, AIHS gained valuable experience in working with high-risk patients within hospital settings during a pioneering five-year demonstration—the Community-based Care Transitions Program (CCTP) (*Journal of Healthcare Contracting*, 2017).

Since CCTP ended in 2015, AIHS and other AAAs have been leveraging the experience gained in working with hospitals to design new business opportunities with healthcare organizations—for care transitions interventions, complex case management, care coordination, and more. Technical assistance for AAAs to master new skills and protocols that these partnerships require has led to a public–private "business acumen" initiative, headed jointly by the Administration for Community Living and the National Association of Area Agencies on Aging (n4a). In 2016, n4a established a new center for this purpose, the Aging and Disability Business Institute (tinyurl.com/y7hh8mwk).

The program's development took twenty-six months and an investment of nearly $500,000.

In August 2018, AIHS launched a Managed Services Organization (MSO) for AAAs and other community-based organizations (CBO), called Preferred Community Health Partners (PCHP).

As of November 2018, the PCHP was operating in seven states, and n4a had agreed to invest as an equity partner in its operation. PCHP fully expects to expand to other states. In its launch, PCHP is contracting with Anthem plans serving individuals with commercial insurance, and the MSO has entered the Medicaid managed long-term services and supports market in one state. Ultimately, PCHP aims to contract with MA plans. The n4a views the equity stake in PCHP as centrally important in supporting AAAs to position their services for older adults through an entity that is based in the aging network and knows the community and its elders.

PCHP was established to deal proactively with common problems and challenges that AAAs have experienced when contracting with managed care plans. Managed care plans would like services on a bigger scale than many single AAAs can easily organize and provide, and they prefer to avoid multiple contracts with individual AAAs. Accordingly, PCHP provides a streamlined, standardized infrastructure for statewide networks of AAAs and CBOs in the following areas: contract management, financial oversight, standard agreements with states, standardized intervention across states, billing and claims support, protocols for tracking outcomes, and IT communication and analytics, including calculations of Return on Investment.

PCHP's development took twenty-six months and an investment of nearly $500,000 to establish initial legal agreements, secure Master Services Agreements (MSA), achieve certification of the health information technology (IT) platform, and structure an operating delivery system framework. The MSA is negotiated and executed at the corporate level and allows for work nationwide under one agreement.

When starting in a new state, PCHP initiates a contract with a managed care plan and commits to arranging for specific services packages to be provided to their members on the ground. The MSO simultaneously recruits AAAs and CBOs interested in delivering those services. One significant advantage to working with PHCP, Jim Vandagrifft, CEO of Preferred Population Health Management, notes that most AAAs still lack access to the IT that allows programs to share data about their shared clients—e.g., data on services use, such as for home-delivered meals and transportation, are in separate systems and do not share information about participants. AAAs also are unable to share data usefully with clinical providers. The PCHP circumvents these shortcomings.

Looking ahead, AIHS's President and CEO Connie Benton Wolfe believes that continued growth for the aging network is linked to shifts toward capitation and other value-based systems that increasingly hold providers financially accountable for providing cost-effective care, and for delivering high-quality services that meet an expanding array of performance metrics. The healthcare system, she said, still has substantial opportunities to reduce use of high-cost services through first—and preferentially—employing the most cost-effective interventions.

CBOs also may work with "age-friendly" and "dementia-friendly" health systems that are based in communities they serve.

Another opportunity on the horizon is a role for AAAs in providing supplemental services paid for by MA plans for their complex care members. Most likely, nutrition and transportation will be the first types of services in this arrangement (Super, Kaschak, and Blair, 2018). As of late 2018, no AAAs had MA contracts, but n4a expects this area to grow quickly. For example, PCHP has been working to secure a MA contract that would use the established infrastructure for service delivery to MA members. Another area for possible development is working with "age-friendly" and "dementia-friendly" health systems that are based in communities they are committed to serving over the long term.

Conclusion

Contracts and partnerships that AAAs and CBOs are forming with MCOs are becoming more streamlined and organized, a trend that benefits community-based care. Similarly, PACE plans are well-positioned to begin outlining the parameters of arrangements with MA plans to improve the cost-effectiveness, quality, and reliability of services for frail older adults. To maximally benefit communities, contracts could consider specifying that a portion of savings realized from avoided high-cost care (i.e., inpatient hospitalization) be invested in community-based supportive service capacity–building, such as workforce recruitment and training, employer support of caregivers, and housing adaptations for disabilities, which generally decrease medical care costs over time (Montgomery, 2018).

These and other types of innovative arrangements will be tested as LTSS assume a more prominent role in healthcare delivery. To address rising demand in the frail elderly population, service capacity for LTSS will need to be steadily expanded in communities across the country. In turn, this may lead to collaborations between MCOs and LTSS providers that deliberately set out to capture savings from avoided high-cost care (primarily inpatient hospitalization), and which can be used to buttress local service capacity.

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References

Bipartisan Budget Act. 2018. H.R. 1892. 115th Cong.

Centers for Medicare & Medicaid (CMS). 2018a. *Reinterpretation of "Primarily Health Related" for Supplemental Benefits*. tinyurl.com/ybcx7o5w. Retrieved October 2, 2018.

CMS. 2018b. *Announcement of Calendar Year (CY) Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*. tinyurl.com/y7jqdxsu. Retrieved November 9, 2018.

Holly, R. 2018. "Anthem Adds Home Care Benefits Under Relaxed Medicare Advantage Rule." tinyurl.com/yajp784z. Retrieved October 25, 2018.

Journal of Healthcare Contracting. 2017. "Care Transitions Programs Meet Discharged Patients in the Home, to Prevent Readmissions and Hasten a Return to Health." tinyurl.com/yclkc4qs. Retrieved October 15, 2018.

Lewis, E., et al. 2017. "The Growth of Managed Long-Term Services and Supports Programs: 2017 Update." tinyurl.com/y7puqtv7. Retrieved November 9, 2018.

Montgomery, A. 2018. "Financial Forecasting for MediCaring Communities." tinyurl.com/y9cy9q3v. Retrieved November 8, 2018.

Norman, J. 2013. "The Aging Population: A Crisis in Plain Sight." tinyurl.com/y9533nmq. Retrieved October 2, 2018.

Open Minds. 2018. "2018 Long-Term Services & Support Market Update." tinyurl.com/yc5jweub. Retrieved October 2, 2018.

Super, N., Kaschak, M., and Blair, E., 2018. "Health Care and Community-based Organizations Have Finally Begun Partnering to Integrate Health and Long-Term Care." *Health Affairs Blog*. tinyurl.com/ycnlphbe. Retrieved October 2, 2018.

New Reimbursement Mechanisms Are Driving New Levels of Competition

By Lori Peterson

In a shifting healthcare sector, value-based care reigns: how best can CBOs remain relevant?

As has happened in virtually every other industry, changing healthcare system dynamics (from volume to value, a rising emphasis on wellness and the influence of the social determinants of health, regulatory change, and rising consumer expectations) are attracting non-traditional competitors from outside the sector. The effect of new entrants such as technology giants and startups seeking to make the delivery of healthcare more efficient and affordable cannot be underestimated. While this situation may feel a world away from the day-to-day realities of managing a community-based organization (CBO), the truth is the landscape has already become more complex as new competitors capture more market share; and the path forward requires CBOs to develop new capacities and execute new strategies to secure new opportunities.

CBOs that prepare for, navigate, and succeed in this evolving landscape stand to reap the rewards by serving more individuals in need (i.e., mission expansion) and acquiring new clients (i.e., market expansion).

Opportunities of the Changing Healthcare Landscape

Payers—whether Medicare and Medicaid or commercial health plans—have taken the lead in shifting the reimbursement model away from delivering services toward delivering value. Because spending too much on medical care that produces average outcomes is unsustainable, payers are creating models that move risk to providers who cannot demonstrate value, while financially rewarding those who can. Better access to quality medical care and improved economic conditions, psychological well-being, good nutrition, and safe housing are linked to better outcomes. Concentrating on improving these social determinants of health presents new potential for social service delivery, new opportunity for organizations to provide these services, and a push for healthcare organiza-

➔ABSTRACT As has happened in many industries, changing healthcare system dynamics (from volume to value, an emphasis on wellness and the influence of the social determinants of health, regulatory change, and rising consumer expectations) attract non-traditional competitors. The effect of technology giants and startups seeking to make healthcare delivery more efficient and affordable has made the landscape more complex for community-based organizations (CBO). CBOs that prepare for, navigate, and succeed in this landscape will reap the rewards; thus, they must develop new capacities and execute new strategies to react to new opportunities. | **key words**: *community-based organizations, healthcare sector, competition, partnership, growth*

tions to enhance their performance by delivering these services.

Healthcare organizations are starting to explore addressing social determinants by providing post-discharge meal delivery, transportation to physician appointments, and home modifications following surgery. Physician practices also are beginning to address social needs by providing community-level care-management services through a new fee-for-service reimbursement opportunity. This has driven healthcare and social service organizations to forge mutually beneficial partnerships, while making it more feasible for healthcare organizations to experiment with providing non-medical services and to better understand the effects such provision has on their clinical, operational, and financial performance.

Concentrating on improving social determinants of health presents new opportunities for delivering social services.

Although there is a strong case that outcomes can be improved, and expenditures reduced through increased investment in social services, financing for such services and programs has thus far come primarily from grants, community-benefit funding, and waivers. No traditional healthcare reimbursement mechanism for non-medical services has existed. Until now.

Beginning in 2019, Medicare Advantage (MA) plans will have the option to cover a wider range of non-medical benefits. This change—part of the 2018 Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act—will reimburse organizations for social services such as meal delivery, home modifications, non-medical equipment, and telehealth, which are aimed at maintaining and improving the health and function of individuals with chronic conditions who live in the community.

All of this could be a boon for CBOs already working to address similar needs and provide relevant services, but because the financial incentives are attractive to any organization willing and able to offer the right solutions, these new opportunities increase the competitive stakes for established CBOs.

The Changing Face of Competition

CBOs often look at healthcare providers and payers as potential partners or new clients. Today, CBOs need to view them as potential competitors. Pressures to demonstrate positive outcomes and reduce costly medical use increase the likelihood that providers and payers will start building their own social service infrastructure, rather than partner with or purchase services from existing social organizations. In one market, for instance, a Medicaid Managed Care plan looking to provide non-emergency medical transportation to its beneficiaries chose to buy vans and hire drivers, rather than to partner with a local CBO already offering this service. In another market, a managed care plan that understood the importance of good nutrition ended an existing pilot with a CBO and began purchasing commercial meals and using its staff to deliver them to older adults living alone in the community.

To a CBO leader, a medical–social partnership may seem like the logical path forward. But for healthcare organizations, the upside to offering in-house services can outweigh the cost and complexity of managing a successful CBO partnership, provide more control over the risks under which they operate, and allow them to deliver more well-rounded solutions, with improved outcomes. With the right incentives in place, taking social services in-house also means enhanced financial performance.

While known healthcare organizations increase the competitive stakes for CBOs, they are not the only players worth watching. As has happened in virtually every other industry, changing healthcare system dynamics are attracting non-traditional competitors from outside the sector. These outsiders bring fresh perspectives, innovative solutions, and substantial resources to move quickly and aggressively. In markets nationwide, digital disruptors like Uber and Lyft are moving into non-emergency medical transportation, national platforms like Mom's Meals are delivering meals to high-need individuals, and for-profit care management and homecare services are applying their business know-how to provide localized solutions at greater efficiency or lower cost.

For such competitors, CBO-style services represent substantial new revenue opportunities, linked to either reimbursement via the MA supplemental benefit or through worthwhile contracts with healthcare organizations that believe that by investing in the delivery of social services they can improve their clinical and operational performance. What these competitors may lack in local know-how (traditionally, a key advantage for CBOs), they make up for in strategic thinking, business savvy, infrastructure, and scale. For this reason, healthcare organizations may opt to partner with competitors such as those mentioned above, rather than with CBOs, which have a history of providing such services in their communities.

Today, CBOs need to view healthcare providers and payers as potential competitors.

As significant as those two new sources of competition may be, CBOs cannot ignore their more traditional competitors: other nonprofit organizations providing similar services. Here though, the focus should not be on other CBOs satisfied with the status quo, but on those that are pushing the envelope. These organizations learn to understand their partners' terminology, operate more like businesses, build interest in and demand for their offerings, replicate effective cross-sector partnership models in other markets, and forge a strategic path toward growth. In doing so, these CBOs position themselves to capture an outsized share of the social services market, even in the face of increased, aggressive competition.

The basic questions any CBO leader should ask are whether their organization has what it takes to compete in this new landscape and whether the rewards outweigh the risks of change. Given that the market for social services continues to expand, the answer to the second question should be obvious. Regarding the first, the answer depends on the CBO's ability to glean insights and apply new strategies and practices from the three types of competitors highlighted above.

How CBOs Can Compete

While there is no set playbook for success in a sector undergoing rapid and continuous transformation, CBOs can triumph through applying a combination of core strengths and bold approaches to create new value. The following four strategies can help CBOs position themselves to compete:

Know the market (really well): One key advantage for many CBOs comes from years, even decades, of experience serving people in the local community. By developing an up-to-date understanding of the population, the challenges it faces, and its evolving needs, a CBO can be laser-focused on practical, effective solutions for that population. Bolster this with a complete understanding of the pressures and priorities of local health providers and payers, knowledge of evolving reimbursement models, and a robust analysis of all potential competitors (not just other CBOs). Market knowledge can improve a CBO's ability to identify emerging opportunities and respond proactively to address existing and new challenges.

Leverage strengths (but don't be limited by them): Every established CBO has a number of advantages for providing value to people, proving value to payers, and positioning itself as valuable to healthcare partners. Advantages may include a proven track record of results, established programs and services and the infrastructure to deliver them, a talented team, and a position of trust within the community. Key drivers for growth will be knowing how these factors provide legitimacy to the CBO and differentiate it from others, understanding how to communicate advantages to others in a clear and compelling way, and having a plan to translate advantages into benefits.

One advantage for many CBOs comes from years, even decades, of experience serving people in the local community.

Strengthen the CBO's position with new capacities: As CBOs pursue growth through acquiring healthcare sector clients, they must establish their status and credibility as experts and equals. This requires CBOs to develop new capacities for thinking, acting, and engaging with performance-oriented healthcare clients on a business level. New capacities include planning and executing a structured business development approach that generates interest and creates demand; designing and delivering fiscally sound programs, business plans, and financial analyses; anticipating, planning for and handling obstacles and objections; and conducting ongoing performance measurement and program optimization. It is equally important that CBOs develop the ability to clearly articulate their expert knowledge, strategic advantages, and the gains of working together—in the context that their healthcare partner can understand.

Go "all in" on partnership and growth: Thriving amid heightened competition requires serious effort, energy, resources, and time, as well as a long-term view. It is easy to be discouraged by early challenges or fall victim to "we tried it once" thinking.

For CBOs to succeed in building new partnerships and capturing new revenue opportunities, they must commit a substantial amount of time to doing the necessary work—conducting research, reaching out, and building relationships and delivery services. They must put the right people in place and allocate sufficient funding to support both a multi-year initiative and a long-term strategy for success.

Ultimately, those CBOs that commit to transforming the way they think, and act will be the CBOs best positioned to capitalize on opportunities inherent in the current marketplace, in which there is a growing emphasis on the social determinants of health and the emergence of new reimbursement mechanisms for services that address them.

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CBOs' Role in Addressing Malnutrition in Community-Dwelling Older Adults

By Brenda Schmitthenner, Andrea Morris, Jessa K. Engelberg, Amy Herr, and Cheryl Hassoldt

Community-based organizations can prevent, identify, and manage malnutrition and malnutrition risk.

Malnutrition, one of the greatest threats to successful aging, is a growing and costly health problem among older Americans that is preventable and can be better managed in the home with support from community-based organizations (CBO). Up to 50 percent of older adults are at risk for becoming malnourished or already are (Izawa et al., 2006; Kaiser et al., 2010), and it is estimated that the annual cost of disease-associated malnutrition in the older adult population is more than $51 billion (Snider et al., 2014). Diseases, including cancer, diabetes, and gastrointestinal, pulmonary, and heart diseases and their treatments can impact both appetite and absorption of nutrients, which can lead to malnutrition (The Malnutrition Quality Collaborative, 2017).

Malnutrition is a complicated and detrimental condition associated with numerous causes and risk factors (National Academies of Sciences, Engineering, and Medicine, 2016). For example, older adults with chronic conditions; functional, sensory, mood, and cognitive impairments; polypharmacy; and oral health problems are at risk for malnutrition. Additionally, with unmet social needs (also referred to as the social determinants of health), such as lack of transportation, food insecurity, poverty, social isolation, and limited or no access to public benefit programs and other essential supportive services, they are at an increased risk for malnutrition. Complicating matters further, these medical and social risks often co-occur, making malnutrition support difficult across the care continuum. As a result, comprehensive malnutrition care requires collaboration between and among healthcare and CBO stakeholders.

Social Determinants of Health and Malnutrition

Malnutrition has long been recognized as a public health crisis in the pediatric population. According to the Academy of Nutrition and Dietetics, it contributes to approximately 45 percent of all child deaths globally, and in the United States, an estimated one in ten households with children struggle with food insecurity. Though malnutrition is pervasive and costly in the older adult population,

➔ABSTRACT Older adult malnutrition is a debilitating and costly condition that can be prevented through engagement from community-based organizations (CBO) that provide care transitions assistance, disease and falls prevention, and health promotion programs. By incorporating screenings for malnutrition and other social risk factors into their programs, CBOs can aid in preventing and treating malnutrition and help older adults to successfully age in their homes and communities, while advancing population health management strategies and demonstrating value to healthcare partners.

| **key words**: *senior and older adult malnutrition, community-based organizations, care transitions, disease prevention, health promotion, social determinants of health, social risk factors*

it remains a silent epidemic, and malnutrition care approaches have not typically been included in most prevention and wellness, patient safety, care transitions, and population health strategies.

Nationwide, there is a growing recognition that poor health is largely attributable to social determinants of health (Marmot, 2005), which often are considered to exist outside of the health system's span of influence. Thus, as healthcare entities employ population health strategies to better manage the health and associated healthcare costs for older patients, they will likely be looking to CBOs to screen for and address the broad range of social determinants of health that contribute to malnutrition risk.

> ***It is imperative to screen for malnutrition and to address the social determinants of health.***

CBOs' role in combating malnutrition

CBOs are uniquely positioned to advance malnutrition care for community-dwelling older adults because CBOs are well-established in their communities and provide a wide array of programs and services that support older adults in their homes, wherein they manage their health on a day-to-day basis. Existing programs and services can be modified and leveraged to screen for and address the social risks contributing to and exacerbating malnutrition. For example, validated malnutrition and screening tools for the social determinants of health can be integrated into program assessments, care transition programs, and disease prevention and health promotion programs.

Malnutrition standards of care, best practices, and validated screening and diagnostic tools are available, and CBOs can systematically adopt them in a community setting and incorporate them into existing program assessments. The Malnutrition Quality Collaborative's (2017) *National Blueprint: Achieving Quality Malnutrition Care for Older Adults* provides a list of validated screening and assessment tools, including the Birmingham Nutrition Risk, Malnutrition Screening Tool, Malnutrition Universal Screening Tool, Mini Nutritional Assessment, Nutrition Risk Classification, Nutritional Risk Index, National Risk Screening 2002, and the Short Nutritional Assessment Questionnaire.

In addition, Seniors in the Community: Risk Evaluation for Eating and Nutrition, Version II (SCREEN-II) is a validated tool developed specifically for community settings (Keller, Goy, and Kane, 2005). These screening tools can detect some risk indicators for malnutrition, including recent weight loss, poor intake of nutrients and-or poor appetite, plus body weight measures (e.g., self-report, calf circumference).

Also, CBOs can add questions into program assessments to identify social determinants of health that contribute to malnutrition, such as those concerning lack of housing and transportation, food insecurity, social isolation, and poverty. The Social Interventions Research & Evaluation Network team created a comparison guide of the most widely used social determinants of health screening tools (Cartier, Fichtenberg, and Gottlieb, 2018); the guide describes each tool and includes information about its intended population or setting, and the social risks each tool addresses.

Effective population health management and value-based reimbursement success hinge on reducing healthcare costs and, according to the 2013 Health Care Cost and Utilization Project data, treating malnourished patients costs nearly twice as much as their well-nourished peers (Fingar et al., 2016). Consequently, proactively screening for malnutrition and addressing the social determinants of health are no longer luxuries, but an imperative.

The Population Health Management Imperative

Effective care transitions are key not only to improving outcomes and preventing avoidable hospital readmissions, but also to implementing health systems' population health management approaches, including risk-based care contracts, Accountable Care Organizations, and bundled payment models. As incentives drive care out of acute care settings, healthcare providers are partnering with CBOs to transition older adults from acute- and post-acute-care settings to home. Across the country, CBOs are using evidence-based care transition models, such as the Care Transitions Intervention and the Transitional Care Model, to support those who are at risk for otherwise avoidable readmissions.

Many of these care transitions programs originated in the Community-based Care Transitions Program (CCTP), which provided a framework for CBOs to partner with hospitals in addressing the needs of high-risk Medicare patients. An evaluation of CCTP concluded that most successful care transitions programs effectively linked patients with community-based services (Econometrica, Inc., and Mathematica Policy Research, 2017).

Effective care transitions are key to achieving health systems' population health management approaches.

Partnerships and screening, educating across the care continuum

While care transition partnerships have connected acute- and post-acute-care settings with CBOs, the lack of sufficient malnutrition identification and treatment across care settings means that patients may be at an increased risk for developing chronic health conditions and frailty, and be more susceptible to falls and loss of independence (Agarwal et al., 2010). Systematically screening for and addressing the social determinants of health for malnutrition across the care continuum, as standard practice in care transition programs, could lessen adverse health outcomes.

Another important focus in the current healthcare environment is on both disease prevention and health promotion. As noted by the Administration for Community Living, evidence-based disease prevention and health promotion programs have been shown to reduce the need for costly medical interventions and are associated with older adults' improved health. Because of this, risk-bearing healthcare organizations are increasingly looking to partner with CBOs to deliver these programs to improve patient care and to lower costs.

The National Council on Aging's National Falls Prevention Resource Center reports that one in four older adults falls every year, and that falls are the leading cause of fatal and non-fatal injuries among elders. Loss of muscle mass and dizziness from malnutrition can increase older adults' risk of falling. Evidence-based fall prevention programs, such as A Matter of Balance, can reduce fall risk, promote physical activity, and improve fall self-management (Haynes, League, and Neault, 2015).

Delivering education about malnutrition to older adult participants in fall prevention programs and incorporating malnutrition screening into workshop programming could be effective for increasing awareness about malnutrition and advancing comprehensive malnutrition care in the community. Embedding malnutrition-specific modules into existing programs could also provide an opportunity to partner with healthcare organizations that are employing population health strategies to improve health outcomes and reduce costly medical care.

There is a similar opportunity to embed malnutrition care components into existing chronic disease self-management programs, particularly given that an estimated 95 percent of healthcare costs for older Americans can be attributed to chronic diseases (Centers for Disease Control and Prevention, 2013). Chronic disease self-management programs encourage older adults with chronic conditions to better manage their conditions. For example, the Chronic Disease Self-Management Program (CDSMP) is a community-based intervention that helps individuals with chronic conditions learn how to manage and improve their health, focusing on challenges that are common to older adults living with any chronic condition (e.g., pain management, nutrition, exercise, medication use, psychological effects of chronic disease, and health self-advocacy).

> **Components that address malnutrition should be embedded into chronic disease self-management programs.**

A national study of CDSMP concluded that the program produced measurable improvements in older adults' health and quality of life, and also reduced healthcare expenditures (Ory et al., 2013). Incorporating course components focused on malnutrition and using the program design to explicitly address and prevent malnutrition (e.g., by targeting nutritional needs and other social determinants of health) would strengthen the value proposition of CBOs seeking to partner with healthcare organizations.

Tailwinds Prevail, Opportunities Abound

The shift from volume-based care to value-based care is rapidly changing how older adult patients receive care. This shift will sustain the long-term tailwinds that are accelerating opportunities for CBOs to support population health management strategies by addressing costs—in human and economic terms—of senior malnutrition. CBOs *can* contribute to improving older adults' health by delivering to them consistent, quality healthcare at an affordable cost. CBOs can achieve these goals by incorporating validated malnutrition and recommended social risks screening tools into their care transition, disease prevention, and health promotion program assessments to effectively address the social determinants of health that contribute to and exacerbate malnutrition.

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References

Agarwal, E., et al. 2013. "Malnutrition and Poor Food Intake Are Associated with Prolonged Hospital Stay, Frequent Readmissions, and Greater In-hospital Mortality: Results from the Nutrition Care Day Survey 2010." *Clinical Nutrition* 32(5): 737–45.

Cartier, Y., Fichtenberg, C., and Gottlieb, L. 2018. "Screening Tools Comparison." tinyurl.com/ybcjkswy. Retrieved October 3, 2018.

Centers for Disease Control and Prevention (CDC). 2013. *The State of Aging and Health in America 2013*. Atlanta, GA: U.S. Department of Health and Human Services, CDC.

Econometrica, Inc., and Mathematica Policy Research. 2017. *Evaluation of the Community-Based Care Transitions Program (CCTP) Final Evaluation Report*. Baltimore, MD: Centers for Medicare & Medicaid Services.

Fingar, K. R., et al. 2016. *All-Cause Readmissions Following Hospital Stays for Patients with Malnutrition, 2013*. HCUP Statistical Brief #218. Rockville, MD: Agency for Healthcare Research and Quality. tinyurl.com/yaejbk89. Retrieved September 6, 2018.

Haynes, M., League, P., and Neault, G. 2015. "A Matter of Balance: Older Adults Taking Control of Falls by Building Confidence." *Frontiers in Public Health* 2: 274.

Izawa, S., et al. 2006. “The Nutritional Status of Frail Elderly with Care Needs According to the Mini Nutritional Assessment.” *Clinical Nutrition* 25(6): 962–7.

Kaiser, M. J., et al. 2010. “Frequency of Malnutrition in Older Adults: A Multinational Perspective Using the Mini Nutritional Assessment.” *Journal of the American Geriatrics Society* 58(9): 1734–8.

Keller, H. H., Goy, R., and Kane, S. L. 2005. “Validity and Reliability of SCREEN II (Seniors in the Community: Risk Evaluation for Eating and Nutrition, Version II).” *European Journal of Clinical Nutrition* 59(10): 1149–57.

Marmot, M. 2005. “Social Determinants of Health Inequalities.” *The Lancet* 365(9464): 1099–104.

National Academies of Sciences, Engineering, and Medicine. 2016. *Meeting the Dietary Needs of Older Adults: Exploring the Impact of the Physical, Social, and Cultural Environment: Workshop Summary*. Washington, DC: The National Academies Press. doi: 10.17226/23496.

Ory, M., et al. 2013. “Successes of a National Study of the Chronic Disease Self-Management Program: Meeting the Triple Aim of Health Care Reform.” *Medical Care* 51(11): 992–8.

Snider, J. T., et al. 2014. “Economic Burden of Community–based Disease–associated Malnutrition in the United States.” *Journal of Parenteral and Enteral Nutrition* 38 (2 Suppl): 77S–85S.

The Malnutrition Quality Collaborative. 2017. *National Blueprint: Achieving Quality Malnutrition Care for Older Adults*. Washington, DC: Avalere and Defeat Malnutrition Today.

The **UCLA Alzheimer's and Dementia** Care Program

By David B. Reuben,
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A model program provides comprehensive, coordinated, patient-centered care to people with dementia.

In the United States, an estimated 5.7 million people are affected by Alzheimer's disease—the most common type of dementia—which touches virtually every family in some way (Alzheimer's Association, 2018). The clinical manifestations of dementia are protean and devastating, including cognitive impairment, immobility and falls, swallowing disorders and aspiration pneumonia, and behavioral disturbances (e.g., agitation, aggression, depression, hallucinations). Spouses, children, and other caregivers and clinicians who take on the responsibility of caring for people with these complex and demanding needs often experience stress, burnout, and illnesses. Thus, dementia can be considered a prototype of complex needs that span the patient and caregiver, medical and social domains, and health system and community-based organizations (CBO).

Many clinicians have neither the time nor, in some cases, the skills to adequately manage many aspects of dementia, including coordinating social and medical care, instructing caregivers, and counseling families. As a result, the quality of care for dementia is poor compared to other diseases that affect older persons (Wenger et al., 2003; Chodosh et al., 2007). Community resources (e.g., the Alzheimer's Association, local adult daycare centers) can help to improve the quality of care by providing caregiver education and support. However, these organizations are underused and poorly integrated into the healthcare system.

Initially funded in part by a 2012 Centers for Medicare & Medicaid Services Innovation Challenge Award, the goals of the UCLA Alzheimer's and Dementia Care (UCLA ADC) program are to provide comprehensive, coordinated, person-centered care linking the healthcare system and the community to maximize patient function, independence, and dignity; minimize caregiver strain and burnout; and reduce unnecessary costs through improved care (Reuben et al., 2013).

Description of the Program

The UCLA ADC program is based at an academic healthcare system and partners with

➔ABSTRACT The UCLA Alzheimer's and Dementia Care program provides comprehensive care based in a health system that reaches out to the community for additional social resources. The program follows a co-management model in which nurse practitioner dementia care specialists provide dementia care in partnership with primary care and specialty physicians. The resulting high quality of care has improved patient and caregiver clinical outcomes, reduced gross Medicare costs, and lowered long-term nursing home placement. New payment models will be needed to support this care and promote dissemination.

| **key words**: *Alzheimer's disease, dementia, care coordination, caregiver support*

CBOs that provide additional social resources. The program uses a nurse practitioner dementia care specialist, with guidance from a physician dementia specialist, who tailors and facilitates dementia care delivery in partnership with the primary care or specialty physician (co-management). Nurse practitioners can write orders, communicate directly through the electronic health record (EHR), and facilitate clinical care. Each dementia care specialist has a panel size of 250 patients and their caregivers and, currently, four dementia care specialists care for approximately 1,000 patients. Although this may seem to be a heavy caseload, dementia care specialists have managed these caseloads for six years and are supported by assistants who help with stable patients.

Many clinicians have neither the time nor, in some cases, the skills to adequately manage aspects of dementia.

Key components to the UCLA ADC include the following:

Recruiting patients to the program and UCLA dementia registry. Patients are recruited into the program through referrals from the UCLA primary care, geriatrics, psychiatry, and neurology practices. We are also developing EHR prompts to encourage physicians to refer patients with dementia who are high healthcare services users. To enroll in the program, the person must have a diagnosis of dementia and a UCLA physician who will partner with and respond to recommendations from the program.

Patient and caregiver are given structured needs assessments. Participation in the program begins with an in-person 90-minute visit with a dementia care specialist, the patient, and at least one family member or primary caregiver. To prepare for the visit and ensure it is efficient, people (if in the early stage of dementia) and-or their caregivers are asked to complete a pre-visit intake form (tinyurl.com/y7cu7ura).

Creation and implementation of individualized dementia care plans. Based on these initial assessments, the dementia care specialist works with the person and family to draft a personal care plan that is sent to the referring primary care physician for approval or modification. This EHR-delivered information is divided into medical recommendations that the primary care physician is asked to address (and respond to through the EHR) and social and behavioral recommendations that the dementia care manager implements independently. When the dementia care specialist has received a response from the partnering physician, the assessment note is finalized and saved to the EHR. The person and-or caregiver then receives a copy of the care plan and a phone call from the dementia care specialist to discuss final recommendations.

All people and their families receive ongoing dementia care management by a dementia care specialist, tailored to their specific patient and caregiver needs and may include the following:

√ In-person sessions at which the person's and family members' specific questions about problems, resources, and implementing care plans are answered;

√ Telephone follow-up to monitor implementation of dementia care plans;

√ Facilitation of appointments with consultants when needed; and

√ Teaching dementia management skills to caregivers through individual counseling, including information on legal and financial planning with referral to community services; behavioral techniques to avoid or manage behavioral problems; and coping strategies for caregivers.

If the person with dementia is hospitalized, patients and their families receive the following:

Communication with the hospital team within 48 hours of admission, including advice on managing dementia-related behaviors, participating in goals-of-care conversations, and facilitating discharge planning and transitions to home;

Communication with and support of the family during hospitalization; and

Follow-up call with the person or caregiver within 48 hours after discharge.

Finally, individuals and their families can take advantage the following program services and resources:

Consultation with neurology, geriatric psychiatry, psychology, or geriatrics for additional diagnostic evaluation or management of refractory complications;

Caregiver support groups, either community-based or provided by the health system, which provides both general and disease-specific support groups;

Caregiver education through a lecture series. These webinars are archived on the program's website (tinyurl.com/ybdmuzhc);

Training videos on how to manage common behavioral problems and challenging situations (e.g., stopping driving; tinyurl.com/ya3pxhqa);

Referral to CBOs for services such as delivered meals, adult daycare, case management, financial and legal counseling, and transportation assistance, as well as caregiver training. (For persons in need of financial help, the program has a voucher system to pay for a limited amount of services, such as individual counseling, complex case management, and adult daycare.);

'The UCLA ADC program is based at an academic healthcare system and partners with CBOs.'

Monitoring and revising care plans, as needed, including active monitoring and support of the caregiver's emotional and physical health. Individuals are categorized by level of acuity. Those with the highest level of acuity (red) (e.g., active crisis) are contacted at least monthly (some require much more frequent contact, including daily, at times); those with moderate acuity (yellow) (e.g., recent hospitalization) are contacted at least every two months; and those who are stable (green) are contacted at least every four months; all participants are seen in person at least annually; and

Adjustments to the care plan, made as deemed appropriate by the dementia care specialist and communicated to the referring physician; access is 24/7, 365 days a year for assistance and advice; daytime calls are handled by the dementia care specialist, and night and weekend calls are managed by on-call physicians who are aware of the program.

Implementation of the program is facilitated by custom-designed dementia care management software that includes case management and quality monitoring features that were created for the UCLA ADC.

Program Results

As of October 25, 2018, the UCLA ADC program has served 2,619 participants and their caregivers. More than 200 physicians have referred patients to the program, and there is a waitlist of more than 250. Based on an analysis of the first 1,091 participants enrolled across a 30-month period from July 1, 2012, to December 31, 2014, the program provided a consistently high quality of care, and improved person and caregiver outcomes (Jennings et al., 2016).

At one year, patient behavioral symptoms improved when measured by the Neuropsychiatric Inventory Questionnaire (NPI-Q) (Kaufer et al., 2000) and depressive symptoms, as seen through the Cornell Scale for Depression in Dementia (Alexopoulos et al., 1988), were reduced.

Caregiver depression scores from the Patient Health Questionnaire-9 (Kroenke, Spitzer, and Williams, 2001), distress related to behavioral symptoms from the NPI-Q (Kaufer et al., 2000), and strain measured with the Modified Caregiver Strain Index (Thornton and Travis, 2003) were all improved (all of these differences were statistically significant) (Reuben et al., in preparation).

The program also reduced Medicare costs by $2,400 per person, per year, and long-term nursing home placement by 40 percent (Jennings et al., in press). After deducting the costs of the program ($1,268 per participant, per year in Los Angeles, in 2013 dollars), the net cost-savings to Medicare were $1,136 per person, per year.

Conclusion

The UCLA ADC program is a practical and comprehensive dementia care program that has been successfully implemented and sustained within a large healthcare system. The program recognizes what people and caregivers will go through together during the course of the person's dementia. Hence, a major focus of the program is on training (including one-on-one training with dementia care specialists, video lectures, managing specific problem behaviors and situations, and referral to CBOs for additional training) and supporting family caregivers, who usually assume this role often unprepared and alone.

> *'The program also reduced Medicare costs by $2,400 per person, per year.'*

The UCLA ADC program has been well-received by physicians and caregivers, resulting in a long waitlist for enrollment. Moreover, it is one of the few clinical interventions for high-need older persons that has met the Centers for Medicare & Medicaid Services triple aim of better care, lower costs, and better outcomes (Berwick, Nolan, and Whittington, 2008).

Although this model of care can reduce fee-for-service Medicare expenditures, current Medicare professional services billing codes do not generate sufficient revenues to cover program costs (Jennings et al., in press). Hence, the financial benefits accrue to the insurer and the costs are borne by the healthcare system. In contrast, Medicare Advantage plans, which assume the risks and benefits of costs of medical care, are positioned to break even or save money by providing these services.

For innovative dementia care models to be adopted by health systems, financial incentives need to be aligned with quality of care and patient/caregiver outcomes. Widespread dissemination of the UCLA ADC will be greatly accelerated if health systems receive adequate compensation to cover the costs of providing this care. New payment mechanisms (e.g., a dementia care management bundled payment or similar value-based service) will be needed to broadly promote adoption and dissemination of dementia care management services provided by the UCLA ADC.

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References

Alzheimer's Association. 2018. *2018 Alzheimer's Facts and Figures*. tinyurl.com/ybcsnrwm. Retrieved May 8, 2018.

Alexopoulos, G. S., et al. 1988. "Cornell Scale for Depression in Dementia." *Biological Psychiatry* 23(3): 271–84.

Berwick, D. M., Nolan, T. W., and Whittington, J. 2008. "The Triple Aim: Care, Health, and Cost." *Health Affairs* 27(3): 759–69.

Chodosh, J., et al. 2007. "Caring for Patients with Dementia: How Good Is the Quality of Care? Results from Three Health Systems." *Journal of the American Geriatrics Society* 55(8): 1260–8.

Jennings, L. A., et al. 2016. "Quality of Care Provided by a Comprehensive Dementia Care Co-management Program." *Journal of the American Geriatrics Society*. 64(8): 1724–30.

Jennings, L. A., et al. 2018. "Health Care Utilization and Cost Outcomes of a Comprehensive Dementia Care Program for Medicare Beneficiaries." *JAMA Internal Medicine* (doi: 10-1001/jamainternmed.2018_5576).

Kaufer, D. I., et al. 2000. "Validation of the NPI-Q, a Brief Clinical Form of the Neuropsychiatric Inventory." *Journal of Neuropsychiatry and Clinical Neurosciences* 12(2): 233–9.

Kroenke, K., Spitzer, R. L., and Williams, J. B. 2001. "The PHQ-9: Validity of a Brief Depression Severity Measure." *Journal of General Internal Medicine* 16(9): 606–13.

Reuben, D. B., et al. 2013. "The University of California at Los Angeles Alzheimer's and Dementia Care Program for Comprehensive, Coordinated, Patient-centered Care: Preliminary Data." *Journal of the American Geriatrics Society* 61(12): 2214–8.

Reuben D. B., et al. "Patient and Caregiver Benefit from a Comprehensive Dementia Care Program." (Manuscript in preparation.)

Thornton, M., and Travis, S. S. 2003. "Analysis of the Reliability of the Modified Caregiver Strain Index." *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 58(2): S127–32.

Wenger, N. S., et al. 2003. "The Quality of Medical Care Provided to Vulnerable Community-dwelling Older Patients." *Annals of Internal Medicine* 139(9): 740–7.

A **Profile in Population Health Management**: The Sandra Eskenazi Center for Brain Care Innovation

By Malaz Boustani, Lindsey Yourman, Richard J. Holden, Peter S. Pang, and Craig A. Solid

This care model emphasizes social, behavioral, and environmental determinants of health when treating dementia.

Alzheimer's disease and related dementias (ADRD) impose significant challenges upon older adults and their caregivers (Friedman et al. 2015; Alzheimer's Association, 2017), who often provide unpaid care. Most physicians providing treatment know that effective care for ADRD and supporting unpaid caregivers requires a more sophisticated framework than is offered by the traditional primary care model. Such a framework values biomedical aspects of health, but places as much emphasis on social, behavioral, and environmental determinants of health, recognizing them as major players in the health of individuals and the population as a whole (Taylor et al., 2016).

Social, behavioral, and environmental determinants influence health directly and indirectly, manifesting as individual behaviors and habits, but also as disparities in access to care (Galea et al., 2011). Through targeted efforts, beginning in 2007, to improve ADRD care for underserved populations in central Indiana, we established the Sandra Eskenazi Center for Brain Care Innovation (SECBCI)—which is affiliated with Indiana University in Indianapolis—in collaboration with Eskenazi Health and community-based organizations such as the Central Indiana Council on Aging Area Agency on Aging and the Greater Indianapolis Chapter of the Alzheimer's Association. This article describes how key aspects of our care model can inform the development of new models of population health management.

Creating a Successful Population Health Management Model

The Eskenazi Health System is a safety-net healthcare system serving a diverse, low-income population in Marion County, Indianapolis. In 2007, SECBCI used strategies that would ultimately become the Agile Implementation model

➜ABSTRACT This article describes how key aspects of the Sandra Eskenazi Center for Brain Care Innovation's (SECBCI) care model can inform other entities on the development of new models of population health management, through a framework that emphasizes social, behavioral, and environmental determinants of health, as well as biomedical aspects. The SECBCI is a collaboration with Eskenazi Health and community-based organizations such as the Central Indiana Council on Aging Area Agency on Aging and the Greater Indianapolis Chapter of the Alzheimer's Association in Central Indiana. | **key words**: *Sandra Eskenazi Center for Brain Care Innovation, Alzheimer's, dementia, social determinants of health*

(Boustani, Alder, and Solid, 2018) to identify and implement evidence-based solutions for managing ADRD. The model's minimum specifications were patient and unpaid caregiver education and support, regular biopsychosocial needs assessment, prevention and treatment of comorbid conditions, medication management, and care coordination among clinical providers and community resources.

During SECBCI's decade-plus existence, we have witnessed first-hand how these specifications allow for more personalized and more effective individual and whole population care. A key factor in the SECBCI's success is that our care for ADRD extends beyond that which is given in the primary care setting, acknowledging and addressing the influence of social determinants in the health and wellness of those with ADRD and their unpaid caregivers. In short, the model has improved care for people with ADRD because of its wider view of care for a defined population.

The model has improved ADRD patient care because of its wider view of care for a defined population.

To expand these lessons to other populations, Eskenazi Health leadership recently convened an interdisciplinary team to discuss elements of a successful population health management model with the following four priorities: an accountable health community; an interdisciplinary, diverse, and scalable workforce; evidence-based care protocols; and a data warehouse with a comprehensive performance feedback loop at the individual and the population levels.

Definitions of these elements and how they work together are as follows:

The accountable health community is a fully integrated (i.e., owned by the same entity or connected through a joint venture) system of community-based and healthcare delivery organizations in a defined community that informs the size and scope of subsequent elements needed to fully support its members.

The interdisciplinary, diverse, and scalable workforce is a team-based approach involving providers and community partners outside the healthcare system. In addition to primary and specialty care clinicians, other critical team members include counselors and health coaches, care coordinators, community health workers and resource navigators, administrators, business developers, and researchers. The diverse skill sets and collaboration with community partners emphasize the importance of social determinants of health. It is a more affordable, scalable, and sustainable approach than clinician-only models. These partnerships between health systems and community services reduce costs by reducing duplicative or unnecessary care, or connecting people with appropriate community services, which may reduce the need for subsequent interventions or hospitalizations, without sacrificing quality.

Evidence-based care protocols ensure the highest quality of care and incorporate multiple determinants of health, including those related to cognitive, physical, medical, genetics, and behavior, as well as non-clinical aspects related to communication and documentation, and social circumstances.

The data warehouse with a comprehensive performance feedback loop requires several characteristics. The first is a reliable and valid sensor, i.e., a means for collecting, monitoring, and alerting about modifiable (e.g., substance abuse, weight, employment) and non-modifiable (e.g., age, sex, race) biopsychosocial information about each population member. The sensor is a set of algorithms that automatically identifies when certain events occur (e.g., a health encounter) or when there are certain combinations of data elements indicating that a person may require additional attention or may be at increased risk for other conditions or adverse events. For example, if a person living alone is diagnosed with cognitive impairment and receives a prescription for medication, the sensor would note that the person may be less likely to adhere to their medication schedule. Then provider(s) can be informed of this in real time.

The sensor may encompass multiple data collection methods, such as specific fields in the electronic health record and-or specific information from administrative and claims databases. It is important that the sensor can collect data on social determinants of health, as well as information related to a person's physical and cognitive functioning. Additionally, the sensor should collect healthcare use and cost data as a way to track care and provide feedback regarding the model's effectiveness.

As mentioned, in addition to collecting these data, the sensor would identify when certain combinations of values indicate that a population member has experienced a significant event or has an increased risk for an adverse outcome. Although the data need to be accessible to providers and those coordinating care, it is crucial that the data also are secure and confidential.

Finally, the data require a specialty unit of qualified individuals to oversee the entire accountable healthcare system and provide a centralized mechanism to coordinate care, which we refer to as the Mission Care Coordination Center, or MC3. This specialty unit of individuals involved in running the MC3 includes an interdisciplinary team involving, at a minimum, a nurse, a social worker, an analyst, and a healthcare administrator to carry out necessary tasks. The MC3 dynamically categorizes and triages the biopsychosocial needs of the population and optimally dispatches the diverse workforce accordingly, while providing timely feedback to that workforce at both the individual case management and population levels. The MC3 is supported by patient-, clinician-, and dual-facing technologies that collect and visualize information and support better decision-making.

The MC3 model reflects recommendations made by the American College of Physicians to routinely screen for and respond to social determinants of health, and account for complexity and variation in how social determinants link to outcomes in different conditions (Daniel, Bornstein, and Kane, 2018).

The advanced track of the Accountable Health Communities model includes a "backbone" organization to "facilitate data collection and sharing among all partners to enhance service capacity" (Alley et al., 2016). As specified in the Accountable Health Communities model, the organization would operate independently from the accountable health community and may not have the ability to determine where the resources are needed the most, or have the authority to get them to the right people, at the right time.

The team-based approach involves providers and community partners outside the healthcare system.

The MC3, in contrast, is an integrated, centralized unit. We believe such a centralized method of care coordination is not only more efficient, but also leads to greater equity within populations, as well as more support for the healthcare providers who care for the most socially complex individuals.

How the Model Functions

To provide an example of how these four proposed elements of a population health model function in practice, consider the fictional case of Mr. Smith, a 72-year-old man who lives with his wife. Mr. Smith presents to the emergency department with a chronic obstructive pulmonary disease (COPD) exacerbation after running out of his scheduled inhalers. He is known to the SECBCI and the larger accountable health community through previous encounters. In addition to cognitive impairment, his past medical history includes Type 2 diabetes, with retinopathy and major depressive disorder.

The four elements of the system work in concert to provide Mr. Smith the best possible care, as follows:

Upon Mr. Smith's arrival at the emergency department, the electronic health record system (the sensor) alerts the MC3, which notifies an interdisciplinary healthcare team (diverse workforce), including his primary care geriatrician, pharmacist, nurse, and social worker.

The emergency department physician stabilizes Mr. Smith with prednisone and inhalers (evidence-based care), the social worker identifies that Mr. Smith is no longer driving due to his cognitive impairment and notes that his wife is in the hospital for pneumonia (social determinants of care collected by the sensor and stored in the data warehouse).

The pharmacist arranges for Mr. Smith to have automated mail refills of inhalers, ensures proper inhaler technique, and adjusts his diabetes medication while on prednisone. Additionally, the pharmacist is informed of Mr. Smith's cognitive impairment and understands the challenges this poses for medication adherence. Thus, the pharmacist checks with a social worker about the current plan to ensure Mr. Smith has the necessary help with his medications, and provides additional instructions regarding the prescription changes.

We believe such a centralized method of care coordination leads to greater equity within populations.

The social worker also coordinates Mr. Smith's transportation for a follow-up appointment with his geriatrician, evaluates and addresses any safety concerns regarding his safety at home alone, and arranges for Meals on Wheels to ensure he has access to food while his wife is absent.

As part of the population health registry for people with COPD, diabetes, and a recent emergency department visit, Mr. Smith is scheduled to receive a follow-up call by a nurse. The nurse checks on his breathing, daily blood sugars, and nutrition, and knows he is being supplied with Meals on Wheels and that no meal adjustments need to be made for his diabetes. However, through the SECBCI-provided care management, he already receives regular follow-ups in person and over the phone that the MC3 schedules and tracks. Instead of separate, unrelated follow-ups for individual conditions, the information from the emergency department visit is relayed to the nurse following up from the SECBCI, and inquiries regarding all conditions are made during a single follow-up call in the next week. Further, additional follow up is scheduled to evaluate his wife's condition upon her discharge to determine whether her ability to care for her husband has diminished, and if so what additional services are required.

The MC3 tracks the percentage of patients with one or more emergency department visits in the past ninety days.

The MC3 tracks the percentage of patients with one or more emergency department visits in the past ninety days, and therefore the emergency department visit represents a significant event in his care. Through review of Mr. Smith's ongoing care use and costs, the MC3 analyst team is able to assess his care's effectiveness, and strategize with the nurse and social worker regarding any additional care needed.

The MC3 team can review whether or not Mr. Smith fills his prescriptions, if he routinely misses appointments, or if he has repeated emergency department visits—patterns of care use that warrant consideration of further cognitive decline, relapse of depression, or inadequate social support. If any of these were present, the MC3 nurse would contact the geriatrician to ensure the issues have been identified and there is a plan to address them. If necessary, the geriatrician can draw upon the interdisciplinary team for assistance and specialized care. In this continuous cycle, all elements remain dynamic and adjust appropriately to changes in Mr. Smith's social and medical determinants of health, the population's needs as a whole, the available workforce, and evidence-based healthcare protocols.

Conclusion

Whether caring for people suffering from chronic conditions such as ADRD or designing a larger population health management model, we can effectively and efficiently incorporate information on social determinants of health into better care for all patients in the system. Understanding how the key components function in concert with one another can allow administrators and providers to fully appreciate their roles and the roles of others within the continuum of care, with the goal of improving overall population health.

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References

Alley, D. E., et al. 2016. "Accountable Health Communities—Addressing Social Needs Through Medicare and Medicaid." *New England Journal of Medicine* 374(1): 8–11.

Alzheimer's Association. 2018. "2017 Alzheimer's Disease Facts and Figures." tinyurl.com/yc5hblbe. Retrieved December 20, 2017.

Boustani, M., Alder, C. A., and Solid, C. A. 2018. "Agile Implementation: A Blueprint for Implementing Evidence-based Healthcare Solutions." *Journal of the American Geriatrics Society* 66(7): 1372–76.

Daniel, H., Bornstein, S. S., and Kane, G. C. 2018. "Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper." *Annals of Internal Medicine* 168(8): 577–8.

Friedman, E. M., et al. 2015. "U.S. Prevalence And Predictors of Informal Caregiving for Dementia." *Health Affairs* 34(10): 1637–41.

Galea, S., M., et al. 2011. "Estimated Deaths Attributable to Social Factors in the United States." *American Journal of Public Health* 101(8): 1456–65.

Taylor, L. A., et al. 2016. "Leveraging the Social Determinants of Health: What Works?" *PLoS One* 11(8): e0160217.

The **Dementia Cal MediConnect** Project

By Brooke Hollister, Jarmin Yeh,
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Improving dementia care via the California duals demonstration.

In 2013, under the auspices of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) initiated a federal demonstration to improve care and control costs for people dually eligible for Medicare and Medicaid (duals). This duals population is characterized by complex and, especially for a subset of the duals group, often costly healthcare needs. Compared to other Medicare beneficiaries, duals are high utilizers of medical care, comprise a disproportionately high number of nursing home residents, and typically face multiple economic, educational, cultural, and linguistic barriers to obtaining quality healthcare (The SCAN Foundation, 2011; Kaiser Family Foundation, 2012; Bynum et al., 2017).

The duals demonstrations integrate medical and long-term services and supports (LTSS)—benefits that are available through Medicare and Medicaid—by improving partnerships between healthcare groups and community-based organizations (CBO), in an effort to limit inappropriate use and control costs (Kaiser Commission on Medicaid and the Uninsured, 2015).

Due to the high level of long-term-care needs for people with dementia, these individuals are likely to benefit greatly from such integration of services. It is estimated that between 19 percent and 25 percent of duals nationwide are cognitively impaired (California Department of Health Care Services and CMS, 2017; Engelhardt, 2018; Medicaid and CHIP Payment and Access Commission, 2018). People with dementia incur triple the Medicare costs of other beneficiaries, costs driven primarily by hospitalizations; and twenty-three times the Medicaid costs of other beneficiaries, due to high rates of institutionalization (Bynum, 2009; Alzheimer's Association, 2018). Through improved care coordination among healthcare entities, LTSS, and home- and community-based services (HCBS), this population could avoid unnecessary utilization of more costly services, delay institutionalization, and lower overall care costs.

California's demonstration for dually eligible beneficiaries, called Cal MediConnect (CMC), provides coordinated medical, behavioral, long-

➜ABSTRACT Healthcare reforms aimed at lowering costs and providing quality care present opportunities for community-based organizations to partner with healthcare organizations to improve care systems for people with dementia and their caregivers. The Dementia Cal MediConnect Project is a promising approach in California's duals demonstration for improving care delivered to low-income people living with dementia and their families. The project is a model for effective advocacy, technical assistance, and dementia training for care managers. Lessons learned from this project may be valuable for those wanting to replicate it. | **key words**: *dementia, care coordination, duals demonstration*

term institutional, and HCBS through managed care organizations. Building on a funding opportunity through the federal Administration for Community Living (ACL), the State of California's Department of Aging partnered with Alzheimer's Los Angeles (LA) to design an intervention to improve identification and care of duals with dementia in ten CMC health plans. In coordination with the Alzheimer's Association's Northern California and Northern Nevada chapter and Alzheimer's San Diego, the following were provided: advocacy and technical assistance to the health plan, and state and federal decision-makers; training on dementia and its care to care managers; and disease education and support services to plan members with dementia and their caregivers.

Advocacy and Technical Assistance to Create System Change

Health plans, CMS, and the state's Medicaid agency were presented with a business and quality rationale to address the needs of people living with dementia and their caregivers. This included data about the disproportionate costliness of this population, typical gaps in care, and the likely poor outcomes for the demonstration if the needs of people with dementia were not met. Alzheimer's LA developed key advocacy talking points, which were delivered by representatives of all three Alzheimer's organizations in their interactions with the identified champions and decision makers (the business and quality case, and the key advocacy talking points are on the Alzheimer's LA website) (Alzheimer's Los Angeles, 2018).

Alzheimer's organizations also were active at the state and local levels in the meetings of duals demonstration stakeholder groups. While time-intensive, these activities allowed the organizations to network with the health plans, learn about the CMC implementation process, and create alliances with other advocacy organizations. Forming informal alliances with prominent and respected CBOs invested in CMC helped reinforce messages, provided additional opportunities to network with health plans, and raised the profile of the project's advocacy agenda.

Additionally, the demonstration offered several policy levers upon which the project was built. While levers differed across states, in California, the three-way contract between CMS, the state, and each participating health plan required dementia training for care managers, and caregiver identification and engagement in care planning (Hollister, Flatt, and Chapman, 2017). Furthermore, through state-level advocacy, additional requirements were added, including a question about cognitive impairment in the mandatory Health Risk Assessment, which is administered to all CMC members.

'Between 19 percent and 25 percent of duals nationwide are cognitively impaired.'

Care manager training

Alzheimer's LA developed a two-part training program for care managers focusing on dementia-capable care coordination. It was delivered locally by three Alzheimer's organizations. The first tier, an eight-hour training, was delivered to nearly 500 care managers in CMC health plans. It presented basic information about dementia; taught how to administer the AD8 (a validated cognitive screening tool); provided strategies for dealing with challenging behaviors; explained the essential role of family/friend caregivers; and reviewed services offered by local Alzheimer's organizations.

An additional second tier, a twelve-hour training, was offered to care managers who were designated to become dementia care specialists. The dementia care specialists would serve as experts in dementia care and a resource for care managers when confronted with challenging issues with this population. One hundred and nine care managers went on to become dementia care managers. Their training focused more deeply on clinical aspects of dementia care, taught attendees how to administer a validated caregiver assessment tool, shared resources for managing common care situations and challenging behavioral symptoms, and emphasized HCBS available through local Alzheimer's organizations and other providers. All training materials are available on the Alzheimer's LA website (Alzheimer's Los Angeles, 2018).

Support services through local Alzheimer's organizations

This project also used an innovative, proactive fax referral tool called ALZ Direct Connect, where members with dementia and their families consented, at the time of the care manager visit, to have the local Alzheimer's organization contact them with information about supports and services. Alzheimer's organizations provided care counseling, support groups, and caregiver education, as well as referrals to community services such as free food pantries, renters assistance, and free legal and financial planning organizations.

Lessons Learned from the Dementia CMC Project

An independent evaluation of the Dementia CMC Project was conducted by the University of California, San Francisco, Institute for Health and Aging. Key lessons learned from interviews with project partners and health plans are described as follows:

Variations in plan structures and cultures meant tailored collaboration. CMC health plans had vastly different care management systems, which reflected the size of the populations they served, the way in which they structured and delegated their services, their degree of integration, and whether they were public or private plans. Based on the size of their membership, their internal resources, and the capacities of provider groups, plans retained or delegated out all or some of their care management tasks to provider groups or contracted entities. Education levels and experience with dementia also varied greatly among care managers and across settings. To effectively work with each health plan, project staff had to learn how the plans were structured and understand their culture for communication and change.

Health plan and state staff turnover made maintaining momentum difficult. High turnover in the plans and at the state's Medicaid agency made it difficult to maintain momentum to make systems changes or to organize trainings. Staff often transitioned between health plans during the project period. Said one project partner, " . . . what is challenging is there [has] been turnover, so relationships will be built and then someone leaves a health plan or leaves a particular position . . . we've . . . found that sometimes they go to another health plan so we're again able to leverage the relationship that [was] already built. And that can actually be very helpful."

In other cases, turnover meant the project would slow down or stop, and project staff would have to start anew in building relationships and gaining buy-in to pursue systems changes. High staff turnover also posed challenges in training dementia care specialists because the trainings are resource-intensive. Online training was explored as a potential solution, but such content is less comprehensive and plans have shown resistance to paying for online training.

Change takes time. Implementation of the Dementia CMC Project ran parallel to the rollout of the CMC pilot. While project staff were able to identify champions within the health plans who valued the project, competing needs and priorities, especially in the beginning of CMC, made systems change slow. Until health plans made headway on the implementation of the overarching CMC pilot, they were unable to focus on dementia-specific systems change. This created a delay in rolling out project activities.

Care manager training was valuable, but insufficient to create change. Despite the slow implementation of system-change indicators, most health plans were eager to initiate care manager training. Project staff viewed training as a prerequisite for system change, but noted that it needed to be coupled with advocacy and technical assistance. Health plans are large, highly regulated organizations that often have several lines of business and operate across county and state lines. Consequently, system changes required thorough analysis and took time to implement. Project partners discussed the iterative nature of their advocacy as crucial to effect change.

'Health plan and state staff turnover made maintaining momentum difficult.'

Another project partner noted: "Change is slow. You have to be persistent, and you have to be present . . . . If you do this for a year and think you're going to make big change happen in one of these systems, you'll be very frustrated. We had been working with some of the plans for four and a half years with changes in their corporate structure and changes in staffing turnover and in federal and state policy."

In most cases, technical assistance and advocacy with health plan decision-makers has been key to them adopting systems changes. For example, use of a fax referral tool, ALZ Direct Connect, was taught in all trainings, but the project found that training alone was insufficient to generate referrals. Only after extensive outreach to the plans were the project partners able to identify and negotiate more systematic adoption of the fax referral form; still, referrals from the plan remain low, indicating the need for further technical assistance and advocacy.

Identifying opportunities to "bake in" systems change. Project partners and CMC plans both noted that the best way to ensure systems change was to "bake in" changes to existing electronic medical records and care management systems and protocols.

"What would be nice, in [an] ideal technical world, would be if someone answered the screening question that's in the health risk assessment with the answer that identifies that there could be a cognitive disorder, [and] that it would automatically show up in the system for the case manager to ask them to do the screening. [Ideally], I think . . . you would just want it to automatically happen, and leave less to the human mind to remember . . . to do that extra step," said a CMC plan partner.

One plan, in discussing how mining their data helped encourage systems change and acknowledging that getting the data into their IT system took time, noted: "We didn't have a good grasp on how many of our members potentially had dementia. Once we identified the scope of the population, we realized . . . we needed to implement several process changes, which also involved changes to IT systems. Plans were set in place, but those changes . . . [took] more time than we had hoped [they would]."

Improving Healthcare for People with Dementia

Medicare beneficiaries living with dementia face multiple challenges to receiving the care they need in HCBS settings. Historically, unless they also have Medicaid, they have limited or no access to publicly funded long-term-care services offered outside of nursing homes. Programs that blend Medicare and Medicaid, like the duals demonstration, PACE programs, and health homes offer opportunities to improve care for this population: they rely upon greater care coordination; they recognize the importance of the family caregiver role; and they create an alignment in the financial incentives to provide better care at a lower cost.

As with the duals demonstration, newer models of care that encourage care coordination and HCBS use present opportunities for the aging network and other HCBS providers to partner with health plans to improve care for people living with dementia. Promising practices and lessons learned from the Dementia CMC Project will be relevant to these models.

California's efforts to improve dementia care in the duals demonstration are currently being replicated with ACL's support in the State of Texas. And following California's lead, the State of Rhode Island's duals demonstration also mandates the training of dementia care specialists. Additionally, the opportunity to access publicly funded HCBS may soon be expanded in a limited way to beneficiaries with Medicare alone.

The recently passed CHRONIC Care Act expands Medicare Advantage supplemental benefits to non-medical services and includes flexibility to offer some types of HCBS, such as adult day services or evidence-based caregiver education that could help plans avoid the costs of unnecessary hospitalizations or institutionalizations. However, because Medicare Advantage plans are only required to support ninety days of long-term care, it is uncertain whether the desire to avoid such costs will be strong enough to incentivize the use of these new HCBS benefit options. Reforms such as CMC provided extra financial incentives to plans by making them responsible for the full extent of HCBS, LTSS, and long-term care.

> ***'We didn't have a good grasp on how many of our members potentially had dementia.'***

Given the growing population of low-income older adults with complex care needs, a managed care approach with well-trained care managers and robust partnerships with CBOs can help support people in the community setting. The potential cost-savings resulting from providing dementia-capable care coordination are likely to make these models attractive to federal and state payers and policy makers for the foreseeable future.

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References

Alzheimer's Association. 2018. "2018 Alzheimer's Disease Facts and Figures." *Alzheimer's & Dementia* 14(3): 367–429.

Alzheimer's Los Angeles. 2018. "Alzheimer's Los Angeles Professional Training webpage." tinyurl.com/yayrsrhd. Retrieved November 15, 2018.

Bynum, J. P. 2009. *Characteristics, Costs, and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1. Medicare Current Beneficiary Survey* (unpublished; provided under contract with the Alzheimer's Association). Lebanon, NH: Dartmouth Institute for Health Policy and Clinical Care, Center for Health Policy Research.

Bynum, J. P., et al. 2017. "High-cost Dual Eligibles' Service Use Demonstrates the Need for Supportive and Palliative Models of Care." *Health Affairs* 36(7): 1309–17.

California Department of Health Care Services and Centers for Medicare & Medicaid Services. 2017. "Informational Bulletin: Cal MediConnect Support for Enrollees with Alzheimer's Disease and Related Dementias." tinyurl.com/ycsm7kzg**.** Retrieved November 15, 2018.

Engelhardt, T. 2018. "Better Serving Dually Eligible Individuals with Dementia Through Integrated Care." October 19 presentation to the NAPA Advisory Council on Alzheimer's Research, Care and Services, Washington, D.C. tinyurl.com/yckj6qtb. Retrieved November 15, 2018.

Hollister, B., Flatt, J. D., and Chapman, S. A. 2017. "Dementia-capable Care Coordination in Duals Demonstration Programs: Workforce Needs, Promising Practices, and Policy." *The Gerontologist* 58(4): 768–78.

Kaiser Commission on Medicaid and the Uninsured. 2015. "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS." tinyurl.com/k47hcxk. Retrieved November 15, 2018.

Kaiser Family Foundation. 2012. "The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare." tinyurl.com/yak27xxk. Retrieved November 15, 2018.

Medicaid and CHIP Payment and Access Commission. 2018. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. tinyurl.com/y9hnv8x3. Retrieved November 15, 2018.

The SCAN Foundation. 2011. "Data Brief: Dual Eligibles—Health Services Utilization." tinyurl.com/ydykvp9o**.** Retrieved November 15, 2018.

An **Advance Directive** for **Dementia**

By Barak Gaster

Documents that can guide care as dementia patients' minds gradually fade.

The disease many people fear most as they get older is dementia. They worry about the progressive loss of cognitive function and the years of dependence this disease inevitably bring. Also, many people have strong views about which medical interventions they would want—or not want—for themselves if they were to develop dementia (Volandes et al., 2009).

Every state in our nation has a statutory advance directive, but these forms generally contain little useful information to guide care if someone were to develop dementia. Instead, they focus on rare conditions, such as a persistent vegetative state or a permanent coma. This creates a major gap in advance care planning because dementia often is the reason that people lose the ability to make decisions about their own care.

Why does this gap exist? Partly because of the complex, slowly progressive nature of dementia. This complexity makes it challenging to state one's views about it, and yet for so many of the years people live with this disease, they no longer have the capacity to guide their own care.

In the early stage of dementia, a stage that can last for many years, people often live full and active lives. This is followed by a gradual loss of the ability to interact with the world around them. Given this slow progression, many people might be expected to want gradually changing goals for their medical care as a dementia illness progresses.

A carefully constructed advance directive for dementia, reflecting the stages of the disease and allowing for gradually shifting goals of care for each of the stages, could allow people to express their wishes if they were to develop dementia.

Creating a Dementia Directive

In 2015, my colleagues and I began to develop a dementia-specific advance directive to address this complexity (Gaster, Larson, and Curtis, 2017). We collected input from experts in the fields of geriatrics, palliative care, and neurology and then pilot-tested versions of the directive with patients.

In November 2017, we released an online version of an advance directive for dementia to the public. It has since been available to all as a free download (Gaster, 2017; www.dementia-directive.org). In the first year after its release, the

→ABSTRACT Many people have clear wishes about which medical interventions they would want—or not want—for themselves if they were to develop dementia. Standard advance directives tend to offer little guidance, however, when people with dementia begin to lose the capacity to guide their own care. A structured advance directive for dementia can fill this gap, providing much needed guidance to healthcare proxies, who often are left making difficult decisions on behalf of their loved ones. | **key words**: *dementia, advance care planning, advance directives, living will*

dementia directive has been downloaded more than 100,000 times, with additional downloads continuing at a rate of about 500 per week.

The structure of the dementia directive is organized around brief descriptions of mild, moderate, and severe stages of the disease. Under each of these descriptions, the directive offers people the same four options, allowing them to indicate what they would want the goals of their medical care to be at a particular stage (see sidebar, below).

The directive offers people the same four options for each stage of the disease.

Guidance from the field of palliative care was especially useful in planning the wording of these options. A particularly important principle was that the options listed should be more than simply checkboxes of interventions which someone would—or would not—want, but should also include value-based reasoning as to why someone might choose one option over another.

For example, the directive includes the option of "do not resuscitate in the event of cardiac or respiratory arrest," and is available for each stage of dementia. The directive then explains that someone might choose that option because they might feel that if they had a cardiac arrest at that stage, there may be too high a risk that after resuscitation they might be left with significantly worsened cognitive function. For some, they might prefer to have a natural, peaceful death at that stage, rather than to risk surviving in a significantly diminished state.

When to Fill Out a Dementia Directive

The best time to fill out a dementia directive is after one reaches age 65, the age at which the risk for developing dementia starts increasing. This age lends itself well to the opportunity to have discussions about advance care planning as part of a Medicare annual wellness visit.

In 2017, Medicare introduced new billing codes for advance care planning, which may include discussions about a dementia directive. These codes can be added to the usual billing used for annual wellness visits. Medicare specifically states these advance care planning services should not incur additional cost-sharing expenses for beneficiaries when such codes are added to preventive care services (Centers for Medicare & Medicaid Services, 2015).

Goals-of-Care Options for Each Stage of Dementia

The following options for care are offered in the dementia care directive, and apply for each stage of the disease:

√ To live for as long as I could. I would want full efforts to prolong my life, including efforts to restart my heart if it stops beating.

√ To receive treatments to prolong my life, but if my heart stops beating or I can't breathe on my own, then do not shock my heart to restart it (DNR) and do not place me on a breathing machine. Instead, if either of these happens, allow me to die peacefully.

√ To only receive care in the place where I am living. I would not want to go to the hospital even if I were very ill, and I would not want to be resuscitated (DNR). If a treatment, such as antibiotics, might keep me alive longer and could be given in the place where I was living, then I would want such care. But if I continued to get worse, I would not want to go to an emergency room or a hospital. Instead, I would want to be allowed to die peacefully.

√ To receive comfort-oriented care only, focused on relieving my suffering such as pain, anxiety, or breathlessness. I would not want any care that would keep me alive longer.

Ideally, people should fill out a dementia directive before they develop signs of cognitive impairment, because once mild cognitive impairment is present, filling out a dementia directive can be difficult. Although people with mild cognitive impairment may still have the capacity to make medical decisions for themselves, filling out a dementia directive may be too complex a task for them. The complex forward-thinking this activity requires may be beyond their reach, as one has to be able to imagine oneself in a future state, then choose what that future self would want if faced with various medical scenarios.

What to Do with a Dementia Directive

Once a dementia directive has been filled out, the most important next step is to discuss the wishes indicated in the directive with the main people who would be most likely to guide one's future care if dementia were to develop. Copies should be provided to each of these people so that documentation of the person's wishes is available to all for future reference.

Patients with dementia may face myriad complex medical scenarios, and each person's experience with dementia is unique. As a result, a dementia directive will never supersede shared discussions between families and physicians in the moment. As such, the conversations that people have with their loved ones before they develop dementia, using the dementia directive as a guide, may be most important of all.

Once completed, people should also mail a copy of their dementia directive to their primary care provider, so that it can be scanned into their medical record. There, it should be made easily available for future reference to help guide medical care if later they develop dementia.

A dementia directive is not intended to replace one's state-approved advance directive. Instead, a best practice would be for a dementia directive to be attached as an addendum to one's state-specific living will. However, if a person has not filled out a state-approved advance directive, a dementia directive still has value as a freestanding communication tool, to help guide healthcare proxies making decisions about care for people who are no longer able to guide their own care.

People often ask whether they should have their dementia directive witnessed or notarized. If someone were very concerned that the document they sign might later be contested, it would certainly make sense for them to take one or both of these steps. Having a dementia directive witnessed or notarized might minimize some of the risk of legal challenge. In most cases, however, even without witnesses or notary, dementia directives can still serve as useful guides for healthcare proxies to use to help them make choices about medical care on behalf of a person who is incapacitated due to dementia.

Rolnick and colleagues (2017) make a strong case for the "delegalization" of living wills. They point out that requiring non-related witnesses, or certification by a notary public, creates barriers to completion of living wills. They argue that the ethical and legal risks, which arise when a patient becomes incapacitated without having filled out an advance directive, are higher than the risks that may come in the less likely event that a directive without witnesses might be contested. Removing these barriers to completion is therefore more likely to be helpful rather than harmful, a conclusion that holds for dementia directives as well.

> ***'A dementia directive is not intended to replace one's state-approved advance directive.'***

The Many Advantages of Dementia Directives

One fear people have about dementia is that they will no longer be able to guide their own medical care. Many worry that they could be forced to have more—or less—invasive medical care than they would have wanted to keep them alive longer. A structured dementia directive can help alleviate this concern by enabling people to express and document their wishes.

Completed dementia directives can also alleviate some of the anxiety family members face when making medical decisions on behalf of a loved one with dementia. Rather than needing to guess what their loved one might have wanted, healthcare proxies can turn to the dementia directive to help them feel more comfortable that the medical decisions they are making on behalf of their loved one more likely reflect what their loved one would have wanted.

The growing value placed on person-centered care and shared decision-making holds that medical care that is more closely aligned with patient wishes is higher quality care (Dy et al., 2015). As the number of people living with dementia in the United States rises, it is incumbent upon us to provide people the opportunity to express—and document—their wishes in the event they lose the ability to make decisions for themselves in the special case of this disease.

A dementia directive is not intended to take the place of the complex conversations that families and physicians will need to have at the bedside. Instead, it is intended to help guide those conversations by giving insight into what a person would have wanted. Making medical decisions that incorporate the person's input, in the form of specific written guidance, will almost always be better than making such decisions without such guidance.

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References

Centers for Medicare & Medicaid Services. 2015. "Advance Care Planning as an Optional Element of an Annual Wellness Visit." tinyurl.com/jd8mmwh. Retrieved September 28, 2018.

Dy, S. M., et al. 2015. "Measuring What Matters: Top-ranked Quality Indicators for Hospice and Palliative Care from the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association." *Journal of Pain and Symptom Management* 49(4): 773–81.

Gaster, B., 2017. "Advance Directive for Dementia." www.dementia-directive.org. Retrieved September 28, 2018.

Gaster, B., Larson, E. B., and Curtis, J. R. 2017. "Advance Directives for Dementia: Meeting a Unique Challenge." *Journal of the American Medical Association* 318(22): 2175–6.

Rolnick, J. A., Asch, D. A., and Halpern, S. D. 2017. "Delegalizing Advance Directives—Facilitating Advance Care Planning." *New England Journal of Medicine* 376(22): 2105–7.

Volandes, A. E., et al. 2009. "Video Decision Support Tool for Advance Care Planning in Dementia: Randomised Controlled Trial." *BMJ* 338: b2159.

Improving Care for People with Chronic Conditions

By Katherine Hayes

> Implementation of the Bipartisan Budget Act can potentially benefit the cohort of Medicare beneficiaries who have multiple chronic conditions.

For the past decade, health policy discussions in Washington, D.C., have led to partisan debates over the merits of the Affordable Care Act. Since the law's enactment, the House of Representatives has voted to repeal or weaken "Obamacare" so many times that there are partisan disagreements over the number of efforts. And any night owl C-SPAN followers will not soon forget watching the late Arizona Republican Senator John McCain cast the deciding vote in the Senate, turning a literal thumbs-down to his own party's repeal-and-replace legislation.

Behind the scenes, however, policy makers have become increasingly frustrated by the partisan divides on healthcare. That frustration, fueled by a desire to address pressing public policy issues, led a handful of senators to take action on addressing policies designed to improve outcomes and lower the cost of care for Medicare beneficiaries with multiple chronic conditions. The Chronic Care Working Group, led by Senators Orin Hatch (R-UT), Ron Wyden (D-OR), Mark Warner (D-VA), and Johnny Isakson (R-GA)—with support from the House Republican and Democratic Leadership—worked to include policy changes in the Bipartisan Budget Act of 2018 (BBA) (BBA, 2018; Bipartisan Chronic Care Working Group, 2015).

The Trump Administration in 2018 used existing regulatory authority to begin these changes in 2019, with the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) finalizing additional regulatory flexibility for Medicare Advantage (MA) plans (CMS, 2018a). These changes lay the groundwork for implementation of the chronic care provisions of the BBA, which provide broader statutory authority for plans to target a wide range of benefits to people with multiple chronic conditions. Those provisions will go into effect in January 2020.

Collectively, these two policy initiatives hold significant potential for improved care in the coming years, but the potential for expanding

➜ABSTRACT In 2018, Congress enacted legislation, the Bipartisan Budget Act, to provide flexibility to Medicare managed care plans by permitting the targeting of supplemental benefits to patients with multiple chronic conditions. This change provides an opportunity to expand care models that have been successful in improving outcomes and lowering use of medical services for people with complex needs. The law has the potential to allow Medicare beneficiaries with multiple chronic conditions and functional limitations to stay in their homes longer, and success in managed care could support expansion to other Medicare payment and delivery models. | **key words**: *Bipartisan Budget Act, Medicare Advantage, supplemental benefits*

these supplemental benefits—benefits not covered in fee-for-service Medicare, but offered by MA plans—to beneficiaries beyond those enrolled in MA depends on agency implementation and MA plan response.

The Bipartisan Policy Center (BPC), under the leadership of former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), has been working in recent years to identify barriers to the integration of services and the expansion of successful care models (BPC, 2016, 2017, 2018). In August 2018, the BPC released a report identifying policy decisions that CMS would need to consider as the agency implemented the BBA.

Striking a balance between beneficiary transparency and flexibility to target benefits will significantly impact the law's success.

The BPC's leaders stressed the importance of striking an appropriate balance between providing flexibility to plans to select supplemental benefits, and to target those benefits to people with multiple chronic conditions (BPC, 2018). Taking those recommendations a step further, it is important to highlight the differences between the 2019 guidance and the statutory language that will guide CMS in developing regulations to guide benefits and targeting for plan year 2020.

Differences Between 2019 and 2020 MA Flexibility

Two issues will be important in the law's implementation. The first is how CMS defines supplemental benefits and what MA plans decide to cover. Historically, MA plans have used supplemental benefits to increase enrollment in MA plans by offering benefits popular with older Americans, such as hearing, vision, and dental care, or to reduce beneficiary out-of-pocket costs (BPC, 2018). Increasingly, successful care models have begun to ask questions about nutrition, housing, and whether patients are living in safe environments, namely, the social determinants of health. Healthcare providers and advocates have expressed enthusiasm over the idea that the new flexibility can be used to address some of these underlying causes of medical conditions.

The second important issue is how plans are permitted to target benefits. It is important for Medicare beneficiaries to be aware of the benefits for which they may be eligible, so rules should be clear. At the same time, if the services must be offered to broad categories of beneficiaries, offering benefits will be very costly to plans, and will discourage plans from offering new benefits (BPC, 2018). Striking the appropriate balance between beneficiary transparency and flexibility to target benefits will have a significant impact on whether the law is successful or not.

Supplemental benefits

Prior to 2019, supplemental benefits have been defined in a way that limited the plans' ability to provide lower cost services and supports to reduce more expensive medical costs. Under the law, benefits had to be "primarily health-related," a term meaning that the item or service is used to "prevent, cure, or diminish an illness or injury." In the past, plans were prohibited from covering items or services that CMS considered to be used for daily maintenance.

Beginning in January 2019, plans will be permitted some flexibility to expand supplemental benefits in MA. Because the Medicare statute allows MA plans to offer healthcare benefits, but does not define them, CMS used its authority to expand its previous interpretation of the term. In the April 2018 guidance, the agency redefined the term "primarily health-related," to mean an item or service that:

> *. . . is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization. A supplemental benefit is* ***not*** *primarily*

health related under the previous or new definition if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes." As an example, the agency cited fall prevention devices as an allowable supplemental benefit. Expanding the definition to include daily maintenance for a "defined period and in certain situations" (CMS, 2018b).

A recent report by the Long-Term Quality Alliance (LTQA) provided insight into MA plans' experience around the expansion of supplemental benefits in 2019. Survey participants reported that many benefits that were suggested by plans were not approved by CMS; these benefits included home-delivered meals and non-emergency medical transportation, primarily because they were not considered health-related (LTQA, 2018). According to an analysis of CMS data, about 40 percent of plans will begin offering new supplemental benefits in 2019. The most common new supplemental benefit is the expansion of Medicare's smoking cessation benefit to include nicotine replacement therapy. A subset of plans will offer caregiver support services, in-home support and personal care services, social worker phone lines, and adult day services benefit (Creighton and Young, 2018).

'Allowable supplemental benefits must be medically related to the targeted enrollee's health status or disease state.'

Many of the plans that have been delaying their decisions about whether or not to expand supplemental benefits until 2020 would like additional clarification from CMS in several areas, including which types of services can be covered. Others have expressed a need for more time to consider member needs, more data on the cost-effectiveness of benefits, and information on consumer response to the added benefits in 2019 (LTQA, 2018). The additional guidance for plan year 2020 was expected to be included in regulations released in November 2018, but CMS provided no additional guidance to plans on which types of services the agency would approve.

In setting parameters for coverage of supplemental benefits, Congress defined supplemental benefits broadly as "items or services that have a reasonable expectation of improving or maintaining health or overall function." The language expressly prohibits the Secretary of Health and Human Services from requiring that the benefit be health-related (BBA, 2018). This language has the potential to greatly improve person-centered care by allowing plans and providers to talk to patients and their families about their goals and to develop a care plan based upon their needs, rather than what is covered under the Medicare program.

If CMS takes the same approach for 2020, plans will submit benefits for approval, and while the agency has considerable flexibility in approving benefits, they will work to consider evidence provided by plans that can improve or maintain health or functional status for complex patients. Because at least a subset of benefits will overlap with Medicaid-covered benefits for those covered by both Medicare and Medicaid, plans that have provided Medicaid long-term services and supports (LTSS) may have valuable experience, as well as plan-level data that could prove to be useful.

Targeting of services

The 2019 guidance permits plans to develop disease-specific benefits for those with chronic conditions (or other serious illnesses) if they are made broadly available to all enrollees with the given diagnosis. Under the guidance, allowable supplemental benefits must be medically related to the targeted enrollee's health status or disease state (CMS, 2018a). This approach limits the ability of plans to arbitrarily decide who receives an item or service and who does not. In establishing guidelines for 2020, CMS also will need to make sure that similarly situated enrollees are treated in the same manner. However, one factor that has been important to improving outcomes and lowering the costs in chronic care models has been the ability to target benefits to meet the unique needs of patients (BPC, 2017). As such, CMS should consider giving plans the flexibility to tailor benefits to a greater degree than diagnosis alone allows.

'Studies have consistently shown that functional status plays a significant role in determining healthcare costs.'

A strong argument can be made for permitting targeting within a diagnosis, because patients with the same diagnosis do not necessarily have the same need for services. For example, two patients with a diagnosis of chronic heart failure might be in very different stages of the disease and have significant differences in functional status. A plan might reasonably expect that providing a stair lift for someone who is no longer able to go up and down stairs unassisted would help maintain health and functional status, and allow that person to remain independent in his or her home for a longer period of time. If a plan were required to provide the same benefit to an enrollee with chronic heart failure who can climb stairs, a stair lift would not be an effective use of plan resources.

Studies have consistently shown that functional status plays a significant role in determining healthcare costs (Ingber, Kautter, and Pope, 2008; Rodriguez et al., 2014). In addition to diagnosis, CMS could incorporate functional assessment as a tool to establish eligibility for supplemental benefits. Plans involved in the delivery of Medicaid LTSS, including MA plans, have experience in performing functional assessments covering items and services based on a person's ability to perform activities of daily living—such as the ability to prepare meals, or to eat, bathe, or dress without assistance. Functional assessment has played a role in Medicare reimbursement and in assessing patient outcomes, and while Medicare does not use a federal uniform functional assessment tool, since 2013, outpatient therapy providers have been required to report functional assessment (CMS, 2018c). Incorporating functional assessment can better align patient needs and benefits.

Looking Ahead

As CMS implements chronic care provisions, it is important to require plans to demonstrate the success or failure of implementing supplemental benefits. Skeptics of MA expressed concern that plans will use supplemental benefits as a tool to increase plan enrollment, rather than to improve the care of patients with chronic conditions. Failure to document supplemental benefits and patient outcomes could lead to increased congressional oversight and efforts to reduce plan flexibility in the years ahead. Building a strong evidentiary base will not only allay concerns over plans' motivations, but also could lay the groundwork for benefit expansion in other Medicare payment and delivery models, and in areas of the country where MA plans are not available.

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References

Bipartisan Budget Act (BBA). 2018. H.R. 1892. 115th Cong.

Bipartisan Chronic Care Working Group. 2015. *Policy Options Document*. Washington, DC: U.S. Senate Committee on Finance. tinyurl.com/ybqxa59u. Retrieved October 29, 2018.

Bipartisan Policy Center (BPC). 2016. *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid* (report from Health Project). tinyurl.com/ychcpqla. Retrieved December 3, 2018.

BPC. 2017. *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries* (report from Health Project). tinyurl.com/ybu5ohu6. Retrieved October 29, 2018.

BPC. 2018. “Improving Care and Lowering Costs for Chronic Care Beneficiaries: Implementing the Bipartisan Budget Act.” tinyurl.com/ya4vdcab. Retrieved October 29, 2018.

Centers for Medicare & Medicaid Services (CMS). 2018a. *Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.* Washington, DC: U.S. Department of Health and Human Services. tinyurl.com/y7jqdxsu. Retrieved October 29, 2018.

CMS. 2018b. Memorandum from Kathryn A. Coleman, Director, Medicare Drug & Health Plan Contract Administration Group, Subject: “Reinterpretation of the Uniformity Requirement.” tinyurl.com/y8qvf5fn. Retrieved October 29, 2018.

CMS. 2018c. “Frequently Asked Questions.” tinyurl.com/yaxgzvxc. Retrieved October 29, 2018.

Creighton, S., and Young, J. 2018. “Medicare Advantage Beneficiaries Will See a Jump in New Supplemental Benefit Offerings in 2019.” tinyurl.com/y9m7vxnv. Retrieved October 29, 2018.

Ingber, M., Kautter, J., and Pope, G. C. 2008. “Medicare Risk Adjustment for the Frail Elderly.” *Health Care Financing Review* 30(2): 83–93.

Long-Term Quality Alliance. 2018. *Medicare Advantage’s New Supplemental Benefit for 2019: Plan Views and Responses*. tinyurl.com/yayj4z6y. Retrieved November 30, 2018.

Rodriguez, S., et al. 2014. *Effective Management of High-Risk Medicare Populations*. tinyurl.com/yakylcde. Retrieved October 29, 2018.

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The SCAN Foundation, The John A. Hartford Foundation, the Administration for Community Living, the Gary and Mary West Foundation, the Marin Community Foundation, and the Colorado Health Foundation have united to fund a three-year grant to develop and establish the Aging and Disability Business Institute (*aginganddisabilitybusinessinstitute.org*), housed within n4a. Under the grant, lead partners ASA and n4a are collaborating on a three-part series of yearly supplements to ASA's **Generations** journal that will help to prepare, educate, and support aging and disability community-based organizations and healthcare payers to provide quality care and services. This supplement, the third in that series, is to the Spring 2019 issue of **Generations**.