Bridging the Community Based Integrated Delivery System with FQHCs

Grantmakers in Aging – Annual Meeting

October 19, 2017
### Five Basic Characteristics of Federally Qualified Health Center

- Located in high need areas
- Comprehensive health and related services (esp enabling services)
- Open to ALL residents regardless of ability to pay — income based fee schedule
- Governed by community boards = response to community needs
- Held to strict performance/accountability standards for administrative, clinical and financial operations

### Federal Support for FQHCs

- Funded through Health Resources & Services Administration (HRSA)
- Federally protected cost-based Medicaid and Medicare reimbursement (PPS)
- Annual federal operation grant
- Malpractice protection under the Federal Tort Claims Act
- Access to discounted pharmaceuticals for patients through 340B Drug Pricing Program
- HRSA Loan Guarantee
Providing more than just primary care

Services Offered by Health Centers

- Primary Medical Care
- Preventative health care
- Prenatal, perinatal & newborn care
- Gynecological care
- HIV Care
- Hearing/Vision screening
- Oral/Dental Health
- Mental/Behavioral Health
- Pharmacy
- X-ray and lab
- Specialty Medical care
- Enabling services

Enabling Services

- Case management
- Environmental health risk reduction
- Health education
- Interpretation/translation services
- Outreach
- Child care (during visits)
- Transportation
- Home visiting
- Parenting education
- Food bank/meal delivery
- Housing assistance
- Employment referral & counseling
Steady increase in 50+ population among health centers

Medicaid expansion helped increase patients 50-64 years old.

Current % of older patients:
- 18% - 50-64 YOA
- 8% - 65+

Community-based organizations can play an integral role in helping FQHCs and CHCs maintain older adults’ independence and quality of life

Benefit under the Medicare Access and CHIP Reauthorization Act (MACRA)

Employ Advanced Alternative Payment Models (APMs) without putting themselves at risk of financial loss
Collaborating with Aging Community Based Providers – Benefits and Opportunities

Community Based Integrative Care

Social Determinants

Population Health

Patient Activation Engagement

Benefits and Opportunities
• Housing, transportation and living environment
• LTSS Supports – Care Transitions
• Level of independence, caregiver and/or social support
• Financial stability and access to benefits
• Cultural and social barriers to care
• Social inclusion

Social Determinants
• Access to health care
• Health disparities
• End of life planning
• Medication management and reconciliation
• Compliance and adherence to care and self-management

Population Health
• Behavioral health supports
• Motivational interviewing
• Chronic Disease Management Programs
• Values, preferences, and advanced directives

Patient Activation Engagement
• Tool to manage health and chronic conditions
• Patient and Caregiver Activation and engagement
Use the Medicare Annual Wellness Visit to create a patient-centered care plan.

Partner with community organizations, such as Area Agencies on Aging, that provide services and support to older adults and their families and caregivers and fill gaps in care.

Initiate advance care planning conversations to identify goals of care, and update as patients’ wishes change over time.

Facilitate better transitions of care by establishing and monitoring relationships with specialty care, local hospitals, and long-term care settings.

Provide training and education of all staff to provide geriatric-competent care.
Strategic Pillars

**ADDRESS SYSTEMIC POverty**
Effect systemic change at scale—from social systems to government programs—so that all people have paths out of poverty.

**CREATE EQUITY**
Support equitable access to quality services and economic opportunity regardless of race, ethnicity, gender, or income.

**BUILD HEALTHY COMMUNITIES**
Foster connections and social supports that strengthen the links between health, education, housing and opportunity that help people and communities thrive together.

**PROMOTE INCLUSIVE GROWTH**
Build diverse, mixed-income communities that promote economic mobility and empower individuals to break the barriers to success.
Launched in 2015 to increase access to quality services for low-income individuals aged 50+

Partnership with AARP Foundation, AARP, Calvert Foundation

$10 Million PRI to leverage up to $70 million with note program

Individuals can invest in the Calvert Foundation Community Investment Note

Loans up to $5 Million

Below market interest rate
Robyn Golden, Rush University
Supporting Primary Care Transformation for Older Adults

Robyn Golden, LCSW
Associate Vice President, Population Health and Aging
Director, Rush University Medical Center GWEP
Opportunities for Enhancing Care for Older Adults

**CHCs/FQHCs generally already offer comprehensive, integrated care under one roof**
- Focusing on older adults can build on this strength
- Plus, increasing the number of high-risk older adults served helps FQHCs meet HRSA grant requirements

**Range of opportunities**
- Ensure providers are trained to be geriatric-competent
- Develop partnerships with Aging Network and other LTSS providers – may not have partnered in past
- Transitional care initiatives
- Offer self-management workshops
- Provide care for family caregivers as well

**Any new organizational strategy requires culture change and new workflows – takes time!**

*CHC:* Community health center
FQHC: Federally Qualified Health Center, CHCs that meet certain federal designations
Geriatric Workforce Enhancement Program

- HRSA grant to support the development of community-specific interprofessional geriatrics education and training programs and to transform care
  - $35.7 million awarded in total, continued funding uncertain
- 44 GWEP initiatives in 29 states across nation
  - Led by health care facilities and by schools of medicine, nursing, social work, and allied health professions
- Rush-led GWEP: CATCH-ON (Collaborative Action Team training for Community Health – Older adult Network)
  - A collaborative GWEP project led by Rush with over 30 educational & community partners across IL
  - www.catch-on.org
Rush’s GWEP: 2 Primary Aims

1. **Education about management of chronic conditions among diverse older adults**
   - Interactive, online education for community members & professionals
   - Course Material & Faculty Development
   - Learning Communities
   - Health Education About LGBT Elders, PEARLS, and Healthy IDEAS
   - Health Ambassadors

2. **Primary care transformation for GWEP partners**
   - Readiness assessment
   - Tailored program development
   - Training and support for clinics
   - Outcome assessment
CATCH-ON
GWEP
Partners

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<tr>
<th>Clinic Partners</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Location</td>
<td>Rural</td>
<td>Rural</td>
<td>Urban</td>
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<tr>
<td>Number of patients</td>
<td>4874</td>
<td>5854</td>
<td>9602</td>
<td>10,262</td>
<td>19,628</td>
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<td>Percent older adults</td>
<td>16%</td>
<td>32%</td>
<td>19%</td>
<td>3%</td>
<td>28%</td>
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Chicago partners:
- Rush University Medical Center
- Lawndale Christian Health Center
- Howard Brown Health
- Cook County Health and Hospitals System
- CJE SeniorLife
- Health and Medicine Policy Research Group
- Continuing Education Institute of Illinois
- Coalition for Limited English Speaking Elderly
- Illinois Cognitive Resources Network

Illinois Association of Area Agencies on Aging
- Southern Illinois University
- Shawnee Health Service

Area Agency on Aging
Assessing Organizational Readiness for Transformation

Readiness Assessment includes:

- Surveys
- Focus Groups
- Scan of environment
- Recommendations
- Implementation support
Results to Date

- Staff and leadership vary in agreement about communication, team function, and available resources
- Feasible, acceptable, and relevant to clinic practice
- Improved team communication
- Recommendations consistent with clinic needs
- Increased awareness of community-based organization services
- Implementation increasing referrals to evidence-based programs
For more information and FREE CE, please visit http://catch-on.org/

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Small Group Discussions
Small Group Discussions

- Two rounds of discussion with table mates
- Identify a recorder/scribe
- Step in/Step out
- Report out to the group
Small Group Discussions – Question 1

What is the connection you see from your perspective on how FHQCs can play a role in supporting community based long-term care?
Small Group Discussions – Question 2

What do you think are the current opportunities for FQHCs and aging partners to come together?
Reflections from group discussions

What aha’s, BFO’s, surprises emerged at your tables? How might we act on this new understanding?

What needs to happen next? Who else needs to be engaged? What strategies require collective action?
Thank you

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