

# Community-based Collaborative Models: Aging Network

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**Lynnzy McIntosh**, Consortium for Older Adult Wellness

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# Community-based Collaboration Models: Aging Network

## Patient-Centered Primary Care Collaborative Annual Conference

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Washington, DC

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# Community-based Collaboration Models: Aging Network

## Overview:

- Why older adults
- What we've learned by listening to them
- What we're doing to improve their health by integrating medical and social services





# The John A. Hartford Foundation

- Private, non-partisan foundation based in New York City.
- Founded in 1929 by John A. Hartford, owner of A&P grocery.
- Mission: improving the health of older Americans.
- New strategies: putting geriatrics expertise to work, fostering improvements in health care delivery.
- [www.jhartfound.org](http://www.jhartfound.org)





# Why Older Adults?

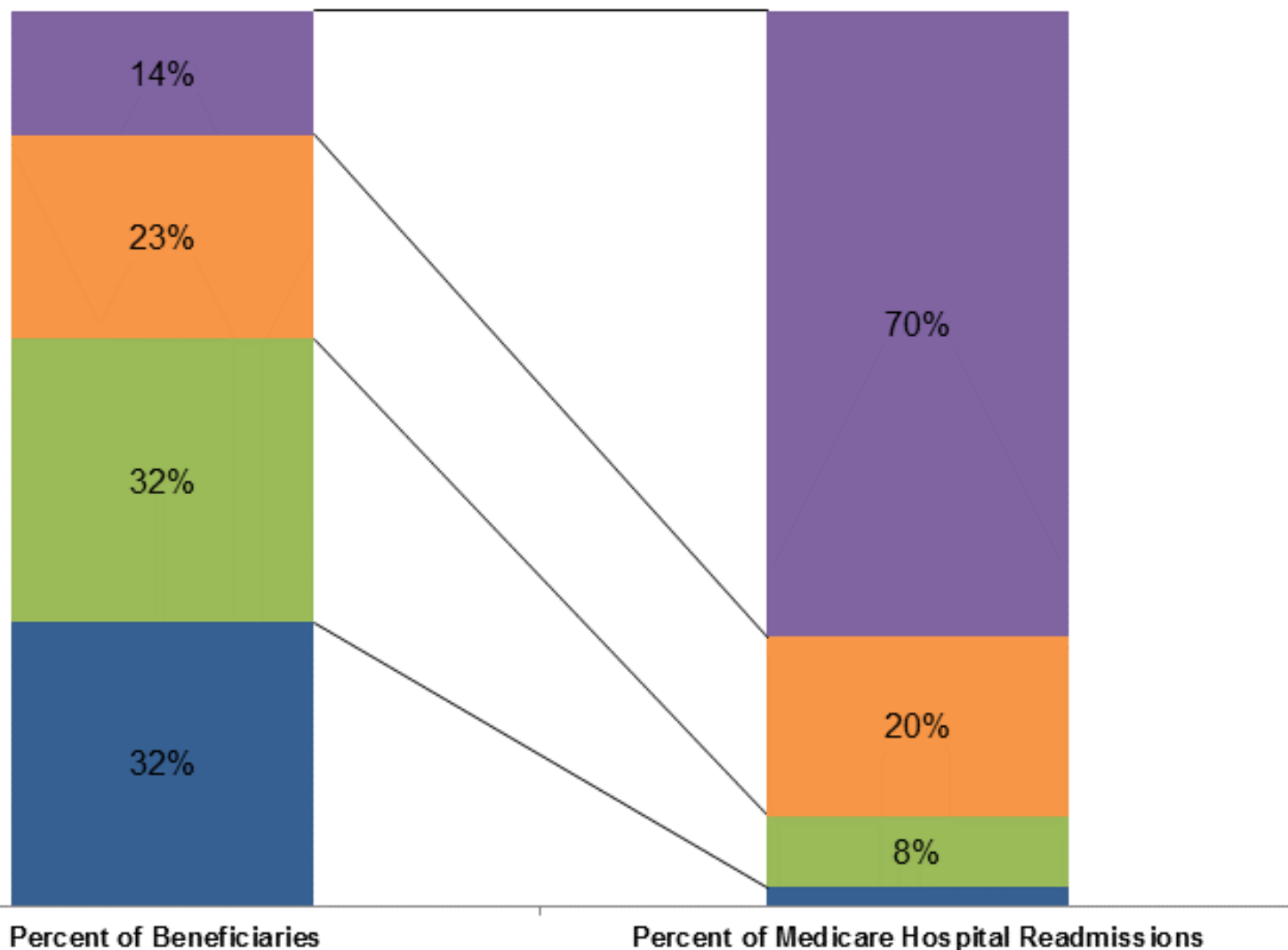
- Happy birthday baby boomers - 10,000 every day!!!
- Major users of health care due to burden of chronic diseases – > 2/3 have multiple chronic conditions, > 1/3 have 4 or more.
- Receive only 30% of indicated care for age-related conditions, fragmented care especially dangerous.
- Have special needs for health care services to maintain independence and function.
- Medical homes and primary care transformation continue to struggle to find the best ways to provide better outcomes and reduce costs.





## Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010

■ 0 to 1 Condition ■ 2 to 3 Conditions ■ 4 to 5 Conditions ■ 6+ Conditions







# Listening to Older Adults: Primary Care Poll Series

\*Each used Lake Research/Knowledge Networks,  
nationally representative samples of over 1,000 age 65+

“How Does It Feel?” Poll (Apr. 2012)	“Silver and Blue” Poll (Dec. 2012)
<ul style="list-style-type: none"><li>• Geriatric services and AWW in primary care</li></ul>	<ul style="list-style-type: none"><li>• Mental Health in Primary Care (oversample of patients diagnosed w/ MH issue)</li></ul>
<ul style="list-style-type: none"><li>• Revealed gaps in prevention and wellness services (from AWW) needed for healthy aging</li></ul>	<ul style="list-style-type: none"><li>• Lack of evidence-based mental health treatment and follow up in primary care</li></ul>
<ul style="list-style-type: none"><li>• <b><i>76% have received less than half of the seven key services</i></b></li></ul>	<ul style="list-style-type: none"><li>• <b><i>62% of all adults 65+ think PCP should have a mental health professional on staff</i></b></li></ul>
<ul style="list-style-type: none"><li>• <a href="http://www.jhartfound.org/learning-center/hartford-poll-2012/">www.jhartfound.org/learning-center/hartford-poll-2012/</a></li></ul>	<ul style="list-style-type: none"><li>• <a href="http://www.jhartfound.org/learning-center/john-a-hartford-foundation-national-public-poll-silver-and-blue-the-unfinished-business-of-mental-health-care-for-older-adults/">www.jhartfound.org/learning-center/john-a-hartford-foundation-national-public-poll-silver-and-blue-the-unfinished-business-of-mental-health-care-for-older-adults/</a></li></ul>

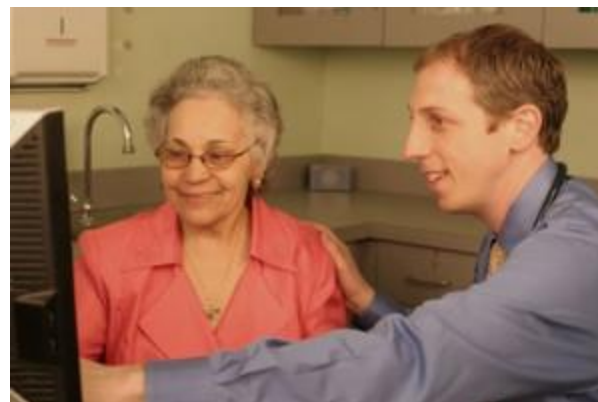


# “On Your Team” Poll (April 2014)

[www.jhartfound.org/learning-center/public-poll-on-your-team-how-older-adults-view-team-care-and-the-medical-home/](http://www.jhartfound.org/learning-center/public-poll-on-your-team-how-older-adults-view-team-care-and-the-medical-home/)

## Overview:

- Explores older adults' experience of **team care** and some of the critical services that are part of **patient-centered medical homes**.
  - Access to care when needed
  - Care coordination
  - Electronic health records
  - Practice-initiated care (e.g. reminders)
  - Medication review
  - Expanded staff
  - Care plan





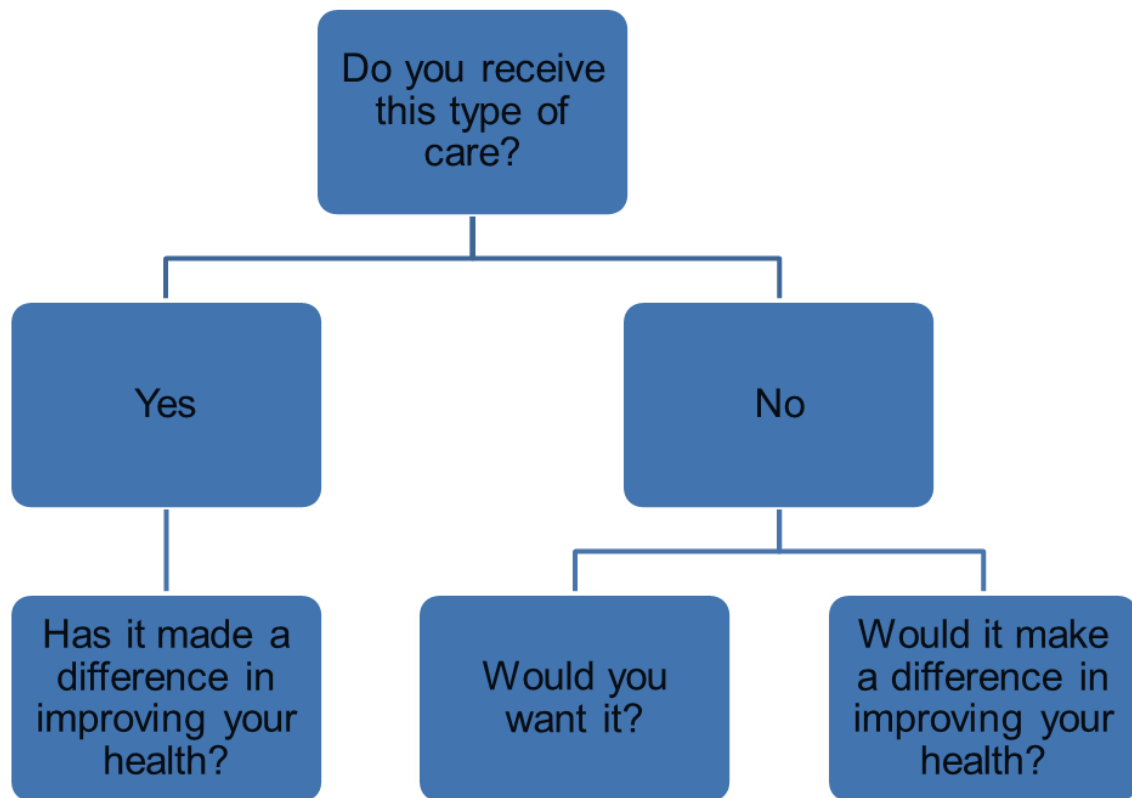


# “On Your Team” Methodology

\*Perry Undem/Knowledge Netowkrs

## “On Your Team” Poll (Apr. 2014)

- Partners:  
PerryUndem
- N = 1,107 adults  
65+
- Fielded: Jan 30  
thru Feb 3, 2014
- Margin of error:  
 $\pm 3.9$  perc points

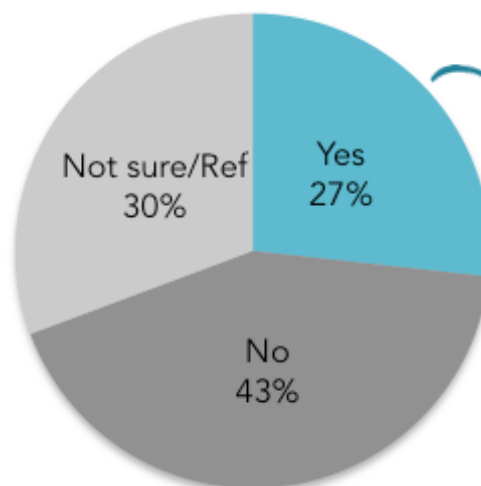




# Team Care

Does this sound like the care you get now?

Base n = 1,107



**83%** say team care has made a difference in improving their health

Base n = 281 who get team care

**73%** would want this type of care\*

**61%** say team care would make a difference in improving their health\*\*

\* Base n = 820 those who do not get team care, are unsure, or do not have a primary care physician

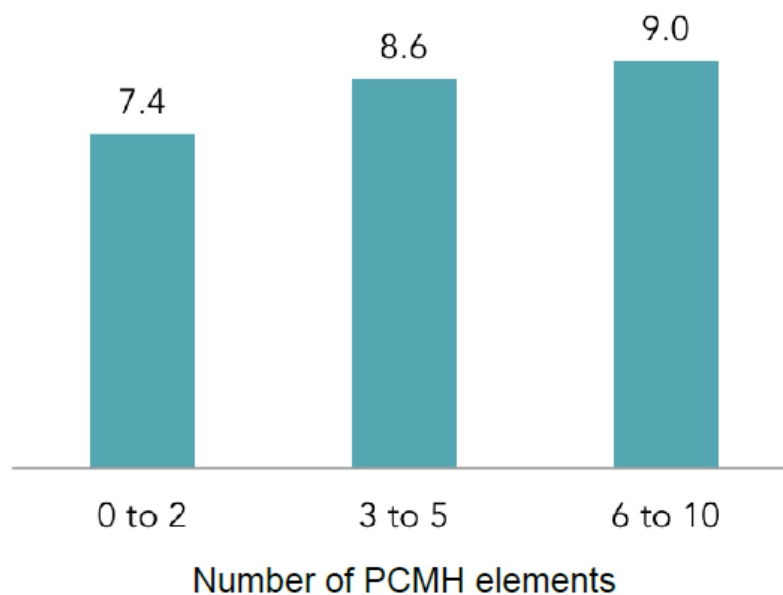
\*\* Base n = 754 those who do not get team care or are unsure



# Satisfaction with PCP

## By Number of PCMH Elements

How satisfied are you with the care you get  
from your primary care provider?  
*Mean Rating 0 to 10, extremely unsatisfied to extremely satisfied*





# Key Take-Aways

- Medical homes and primary care transformation continue to struggle to find the best ways to provide better outcomes and reduce costs. – complex older adults are an opportunity
- Older patients' view of their own health and health care matter and can (and should) inform this redesign.
- Key findings reflect that older patients like the kind of team care delivered in medical homes. For example:
  - 84% would want PCP to initiate follow-up care
  - 57% would want reminders re: immunizations and preventive care
  - 61% would want a written list of medications
- Most aging Americans who receive team care and the services of patient-centered medical homes say it is actually improving their health.
  - 83% who get these services say it has improved their health





# Geriatrics Expertise and Models of Care Needed

- Care Management Plus: Oregon Health & Sciences University  
([caremanagementplus.org](http://caremanagementplus.org))



- “IMPACT” Evidence-Based Collaborative Care for Depression: Advancing Integrated Mental Health Solutions Center at the University of Washington  
([aims.uw.edu](http://aims.uw.edu) & [impact-uw.org](http://impact-uw.org))

**AIMS CENTER**  
Advancing Integrated  
Mental Health Solutions



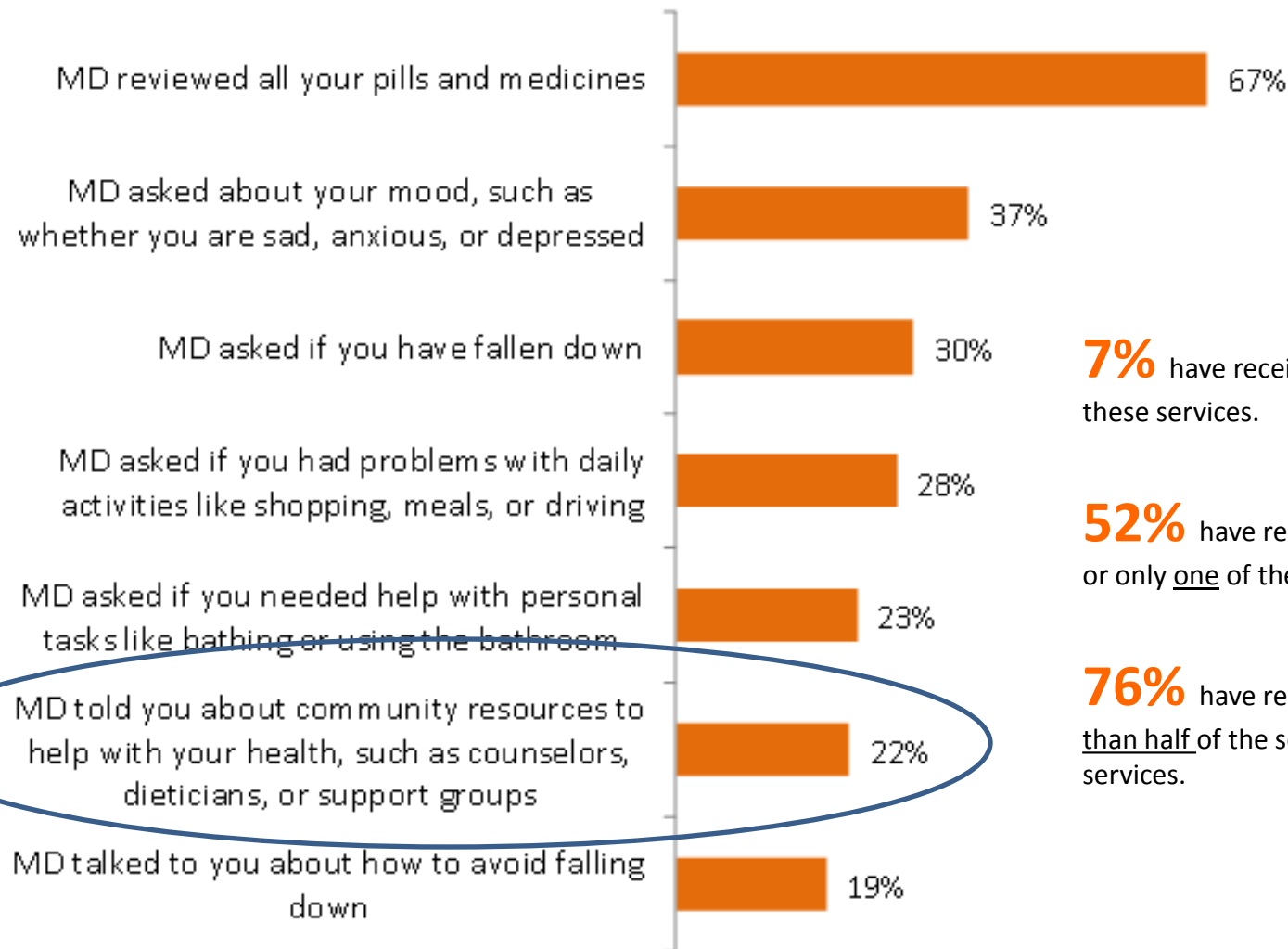
**IMPACT**

- GRACE Team Care: Indiana University/SCAN Foundation  
([graceteamcare.indiana.edu](http://graceteamcare.indiana.edu))



# “How Does it Feel” Poll 2012

Percent saying “yes” has happened in past 12 months



**7%** have received all of these services.

**52%** have received none or only one of these services.

**76%** have received less than half of the seven key services.

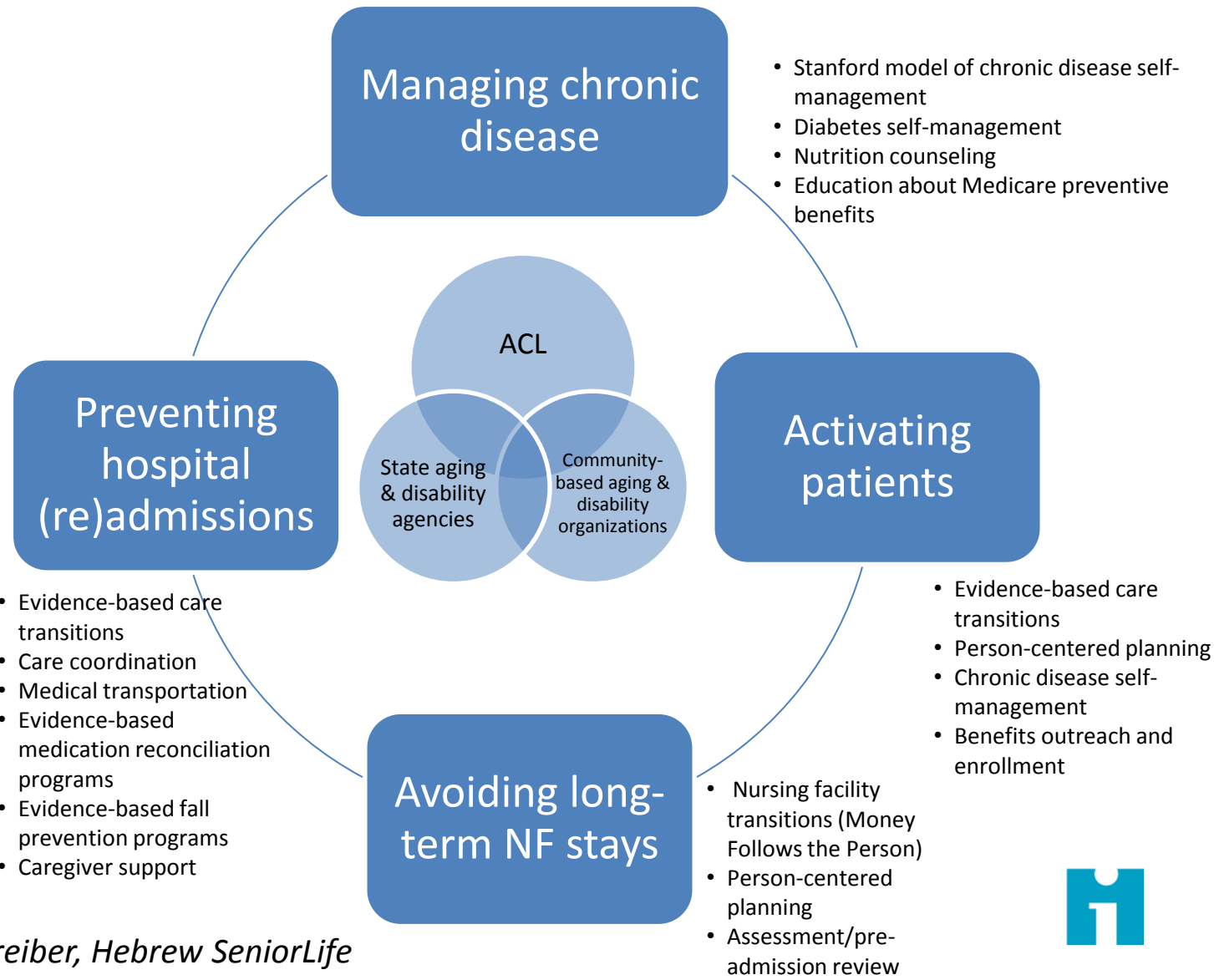


# Aging Network Expanding Scope to Meet Client Needs

## Traditional Scope of LTSS Services

- *Home-delivered and congregate meals*
- *Transportation*
- *Medication reconciliation*
- *Respite/Caregiver support*
- *Falls/Home risk assessments*
- *Information and assistance*
- *Personal care*
- *Employment-related supports*
- *Homemaker*
- *Shopping*
- *Money management*

## Expanded Scope of Services





# Improving the Health of Older Adults Using Integrated Networks for Medical Care and Social Services



A regional network in Southern California  
led by Partners in Care Foundation. (***picf.org***)



A state-wide approach in Massachusetts  
led by Elder Services of the Merrimack Valley and  
Hebrew SeniorLife. (***healthyliving4me.org***)



Convening the National Learning Collaborative  
of 9 sites receiving Technical Assistance from  
the Administration for Community Living (ACL)



# Thank you

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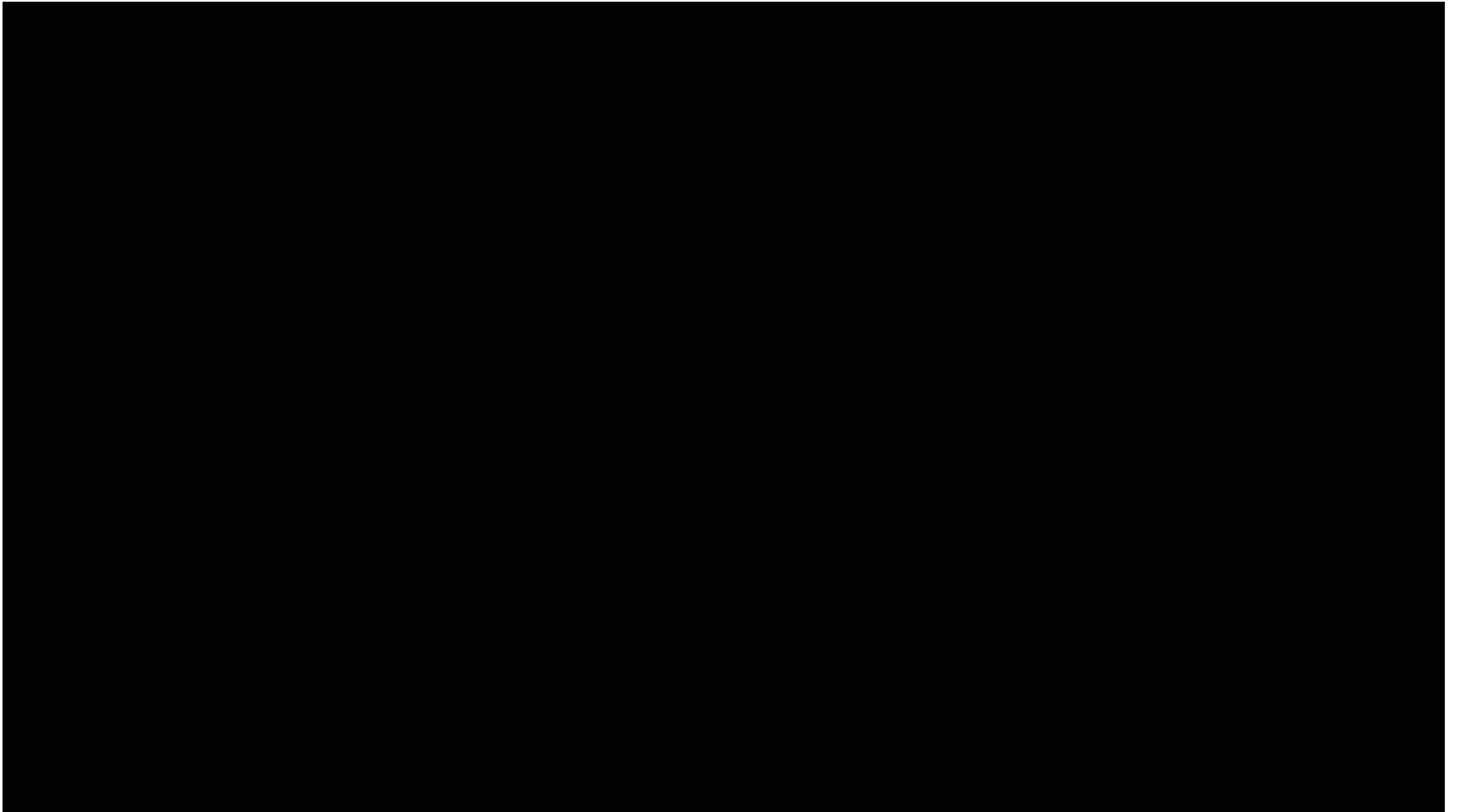


# Clinic-to-Community Connection

**When you want something  
You've never had,  
You have to do something  
You've never done.**







# Centura Health System



St. Anthony Hospital  
Centura Health.

We need activated patients

# City of Lakewood



We need healthier residents

# Consortium for Older Adult Wellness



We connect health systems to  
community resources



# Key Components





# Key components

- Patient Referrals
- Action-oriented Health Education
- Active lifestyle opportunities



# Healthy Lakewood Program Design



- Program Assessments
  - Education
    - Coaching
      - Lifelong Opportunities

# Healthy Lakewood Program Design



## Program Assessments

# Healthy Lakewood Program Design



## Education

# Healthy Lakewood Program Design



## Coaching

# Healthy Lakewood Program Design



## Lifelong Opportunities





# Making Connections





# Connecting to the Health Coach

# Connecting to Self-Management Education



Consortium for Older Adult Wellness



# Connecting to Parks & Recreation Services

# Outcomes and Measures



Bio Impedance Analysis (BIA)



# Outcomes and Measures



Patient Activation Measure (PAM)

# Outcomes and Measures



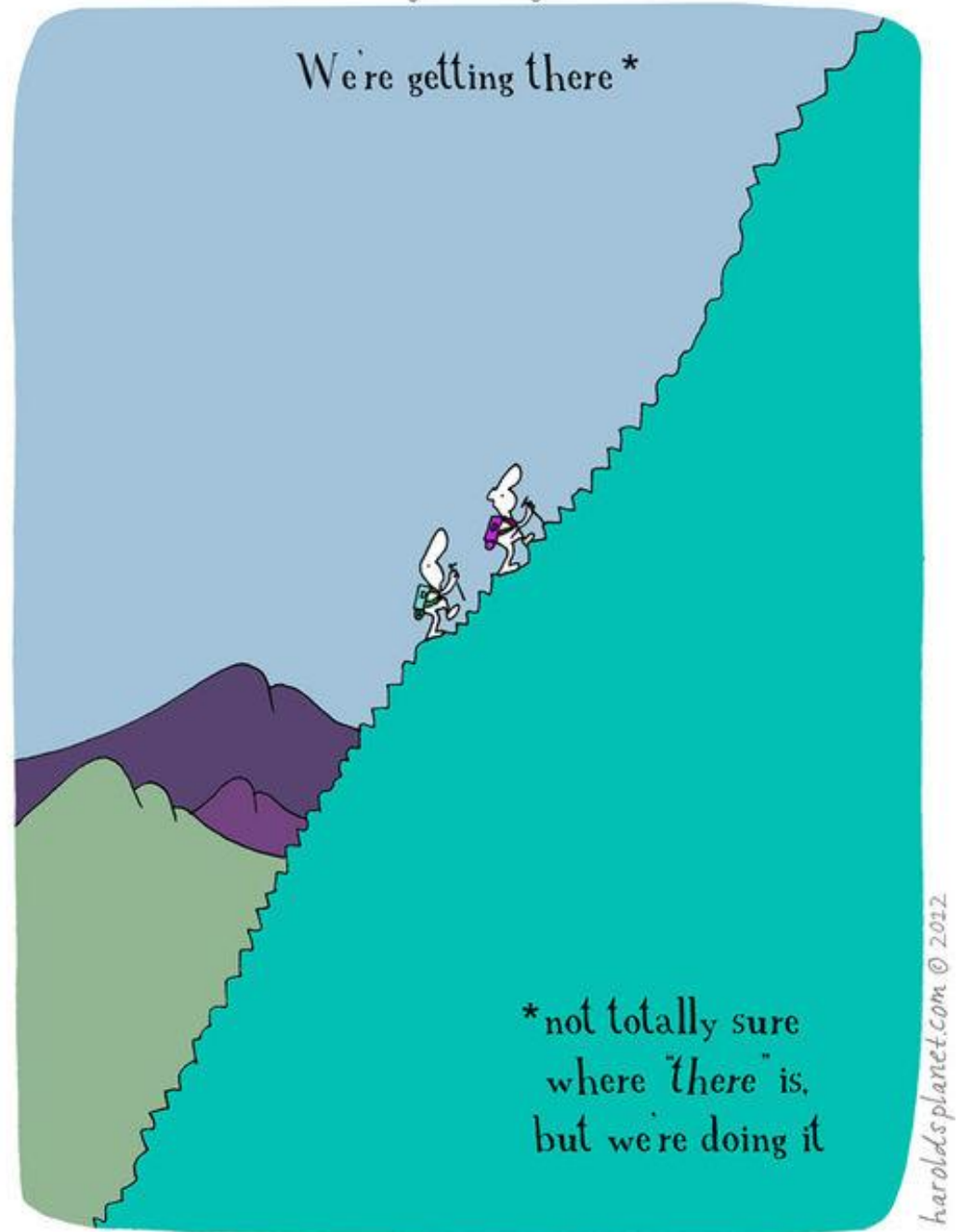
Wellness Wheel Assessment



# Establish a Common Goal



# Questions and Comments





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