Care Team Model
Benefits and Expected Impact

For ALFs and Retirement Communities

VANTAGE HEALTHCARE

Introductions

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Agenda

- Introductions
- ALF residents & their health care needs
- Care coordination needs in ALFs
- ALF coordinated care study
- Care Team model at ALF and expected benefits
- Chronic Care Management (CCM)
- Next steps for ALFs
- Q&A

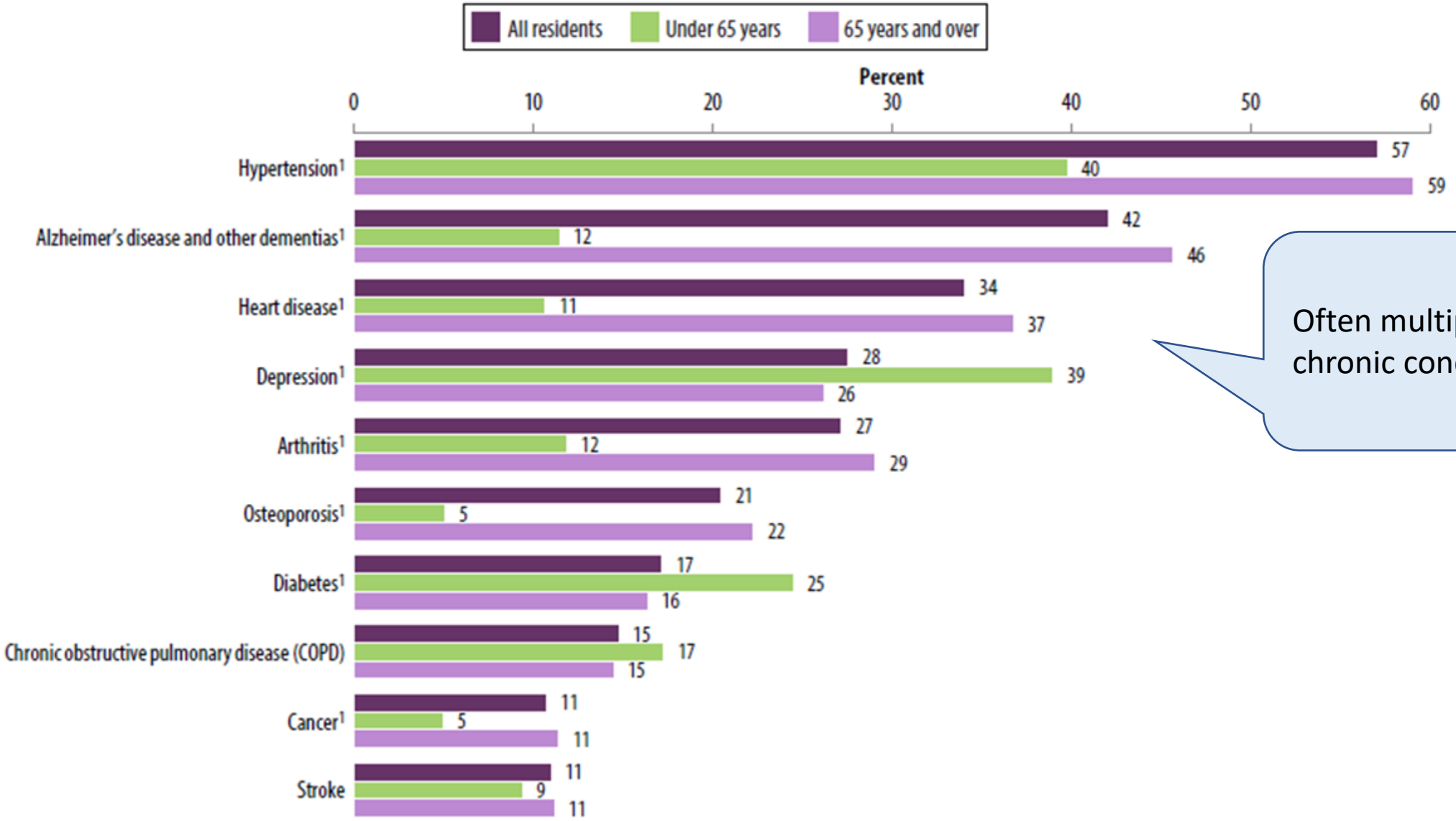
ALF Clinically Integrated Care Model

Provider Care Team

- **Medical**
  - Physician
  - Nurse Practitioner
- **Behav-ioral**
  - Psych NP
- **Care Coord-inator**
  - Licensed Nurse

National Center for Health Statistics 2016 study “Residential care communities and their residents in 2010: A national portrait”.

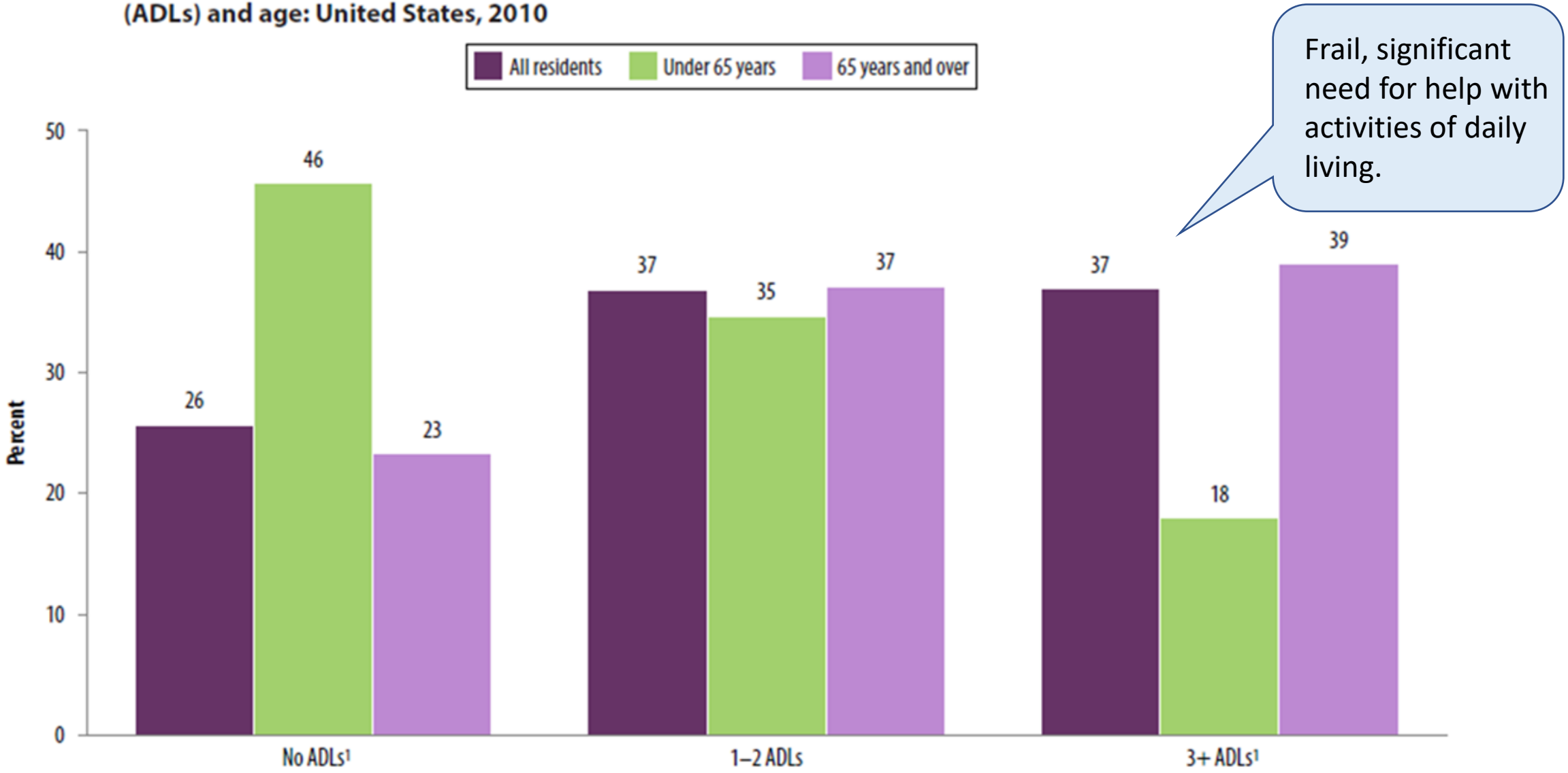
FIGURE 3-1 Percentage of residential care community residents, by the 10 most common chronic conditions and age: United States, 2010



Often multiple chronic conditions.

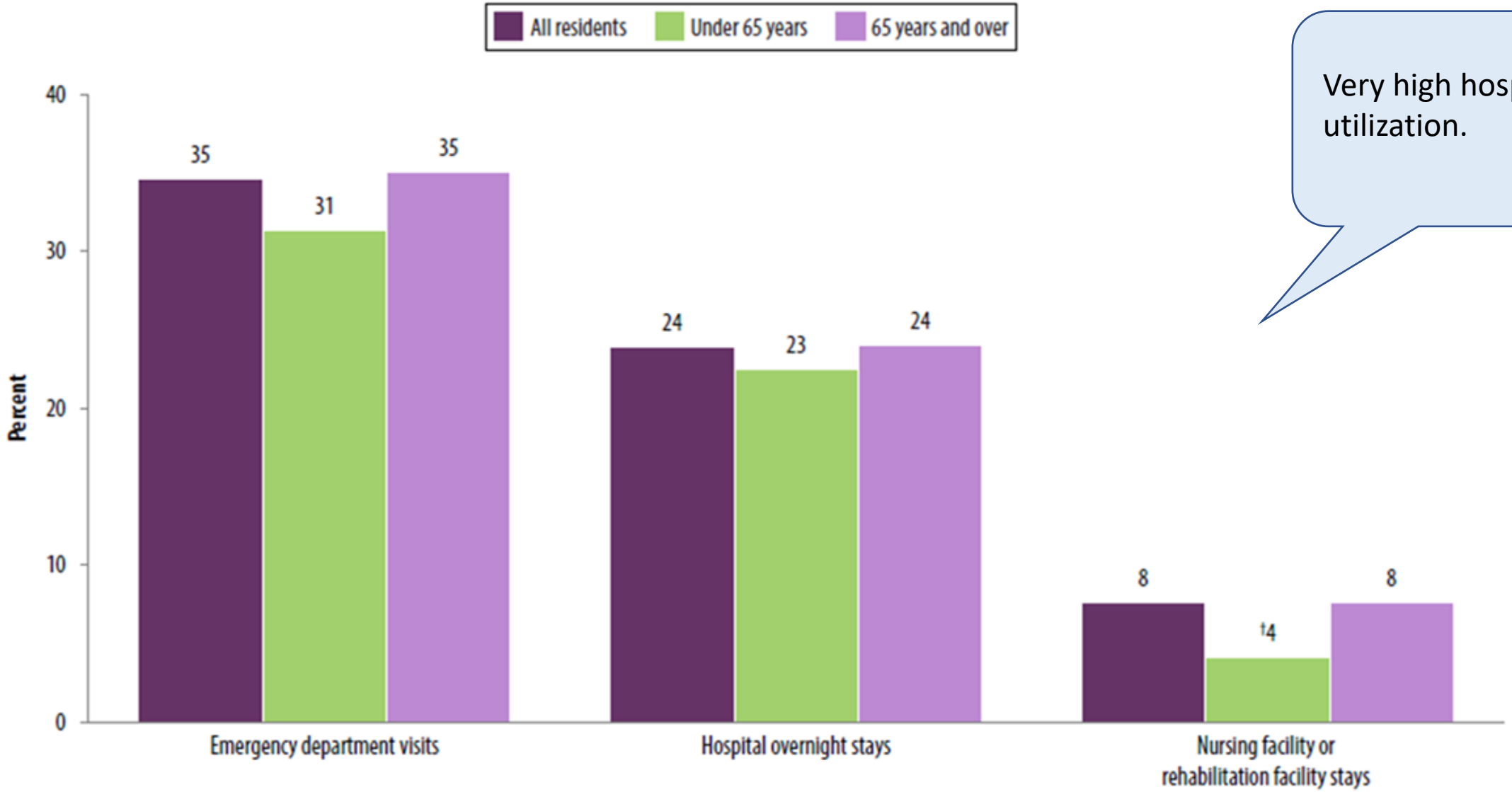
Khatutsky G, Ormond C, Wiener JM, Greene AM, Johnson R, Jessup EA, Vreeland E, Sengupta M, Caffrey C, Harris-Kojetin L. Residential care communities and their residents in 2010: A national portrait. DHHS Publication No. 2016-1041. Hyattsville, MD: National Center for Health Statistics. 2016.

FIGURE 3-5 **Percentage of residential care community residents, by assistance with number of activities of daily living (ADLs) and age: United States, 2010**



Khatutsky G, Ormond C, Wiener JM, Greene AM, Johnson R, Jessup EA, Vreeland E, Sengupta M, Caffrey C, Harris-Kojetin L. Residential care communities and their residents in 2010: A national portrait. DHHS Publication No. 2016-1041. Hyattsville, MD: National Center for Health Statistics. 2016.

FIGURE 3-9 Percentage of residential care community residents, by use of emergency department, hospital overnight, and nursing facility or rehabilitation facility in the past 12 months and age: United States, 2010



Very high hospital utilization.

Khatutsky G, Ormond C, Wiener JM, Greene AM, Johnson R, Jessup EA, Vreeland E, Sengupta M, Caffrey C, Harris-Kojetin L. Residential care communities and their residents in 2010: A national portrait. DHHS Publication No. 2016-1041. Hyattsville, MD: National Center for Health Statistics. 2016.

Fragmented, unaffiliated services, providers, and programs; often multiple of same type of service, provider, or program; and systems and processes are not integrated. Onsite and offsite services often include:

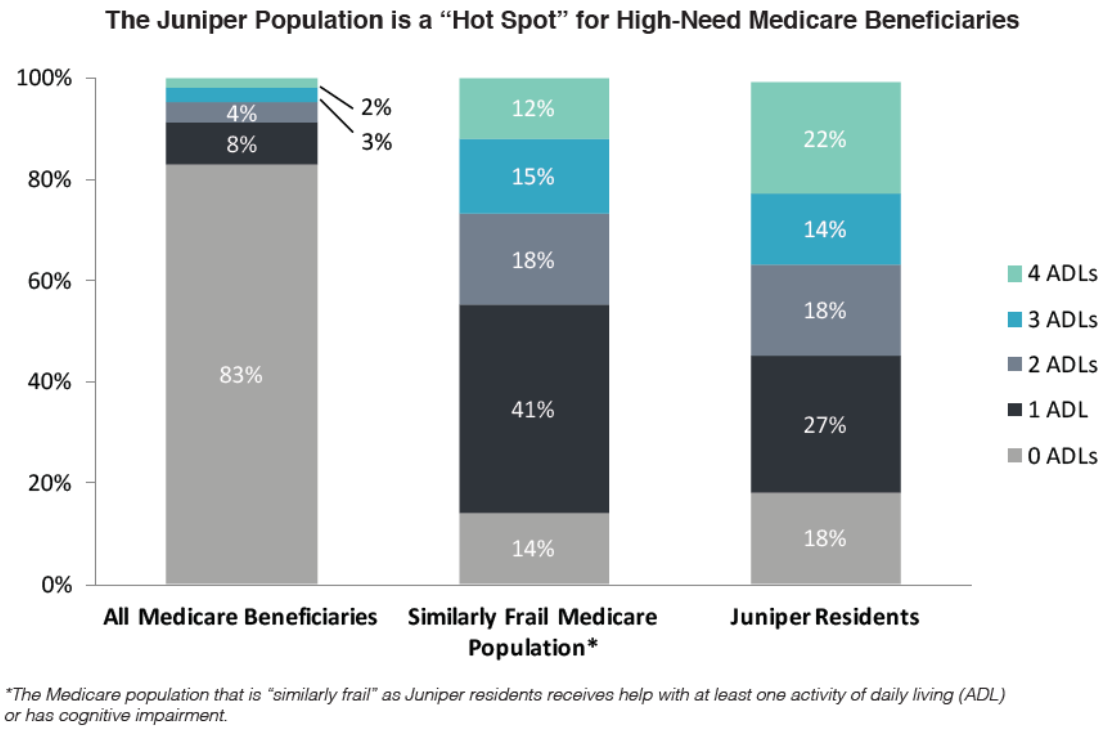
- ALF clinical staff
- Primary care physician
- Nurse Practitioner
- Behavioral health
- Home health
- Outpatient rehab
- Pharmacy
- Lab
- X-ray
- Ambulance
- Dental
- Podiatry
- Optometry
- Specialists
  - Cardiologist
  - Pulmonologist
  - Neurologist
  - Urologist
  - Dermatologist
  - Psychiatrist
- Emergency department
- Hospital
- Skilled Nursing Facility
- Rehab Hospital
- Optometry
- and more.

Anne Tumlinson Innovations study of Juniper Communities Connect4Life integrated service delivery care model program results.

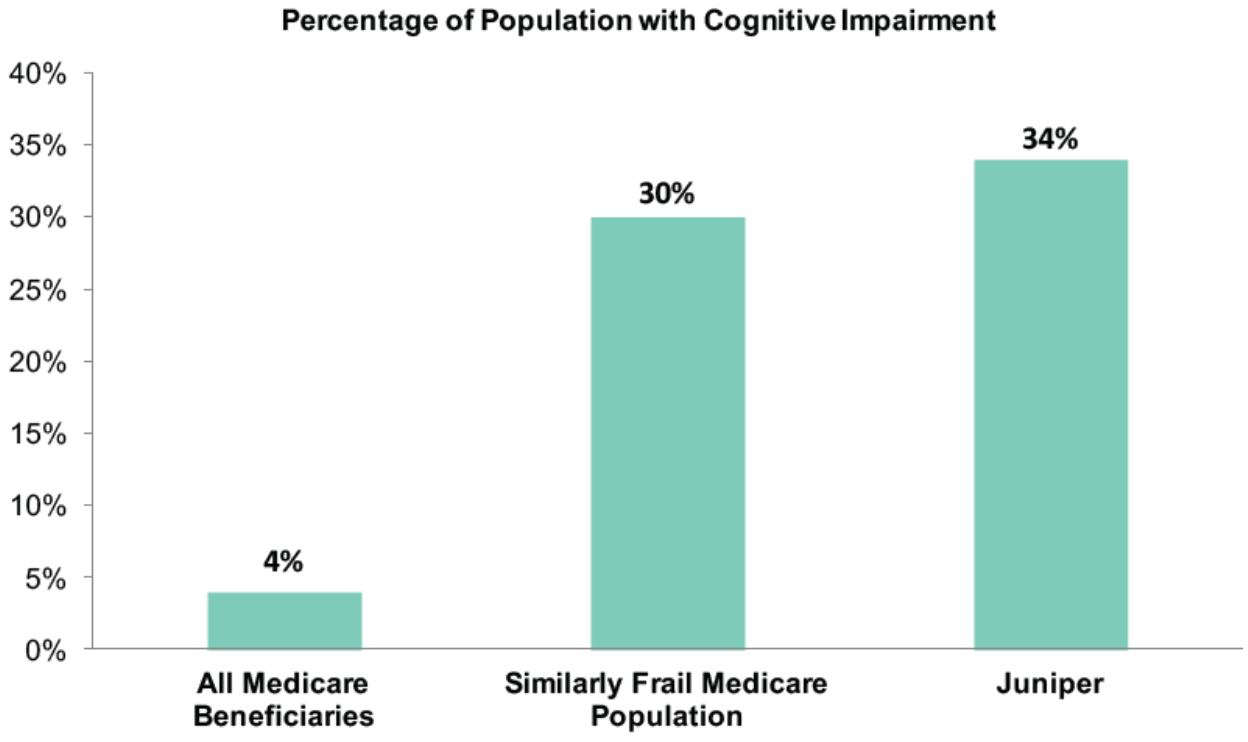
Juniper Communities offers assisted living and memory care in 15 communities located in Pennsylvania, New Jersey, Colorado and Florida.

Findings from Anne Tumlinson, MMHS and Lynne Katzmann, PhD, March 2017 study of Juniper Communities integrated care team model "Integrated Care in Seniors Housing that Meets the Triple Aim"

Juniper resident needs similar to "frail Medicare population" comparison group



*The Medicare population that is "similarly frail" as Juniper residents receives help with at least one activity of daily living (ADL) or has cognitive impairment.

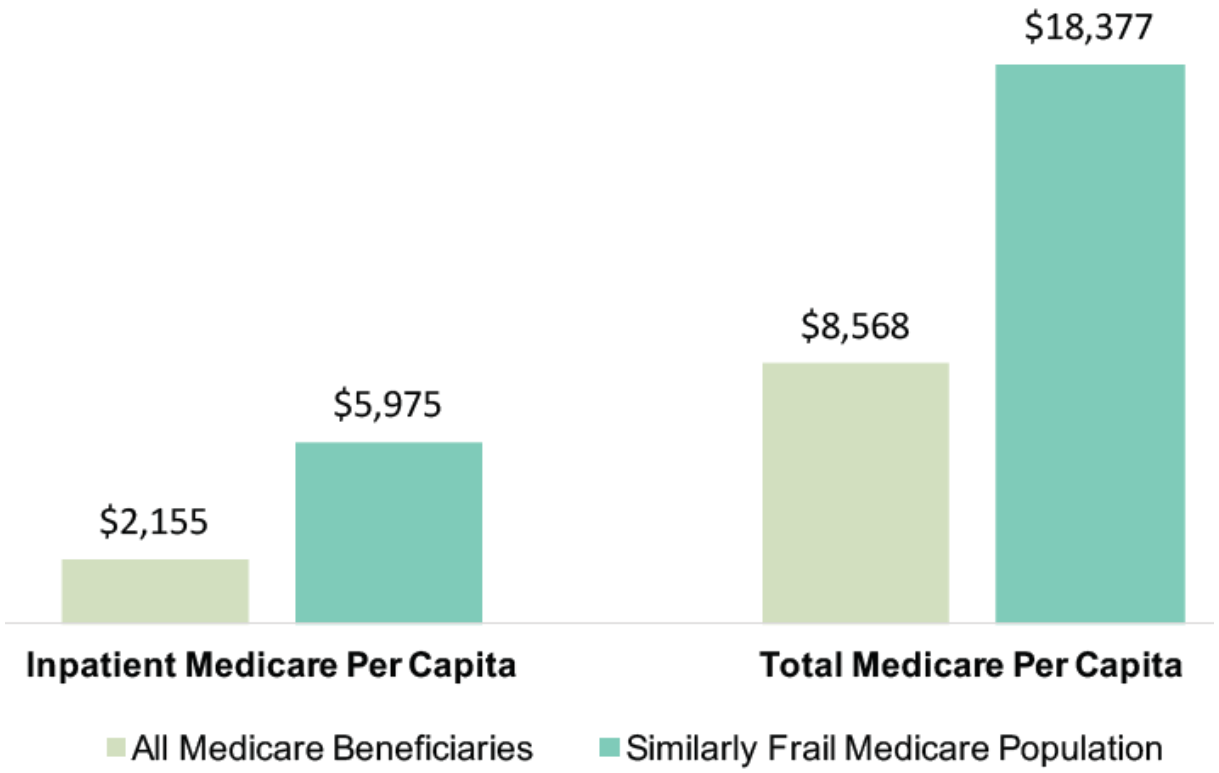


Findings from Anne Tumlinson, MMHS and Lynne Katzmann, PhD, March 2017 study of Juniper Communities integrated care team model "Integrated Care in Seniors Housing that Meets the Triple Aim"

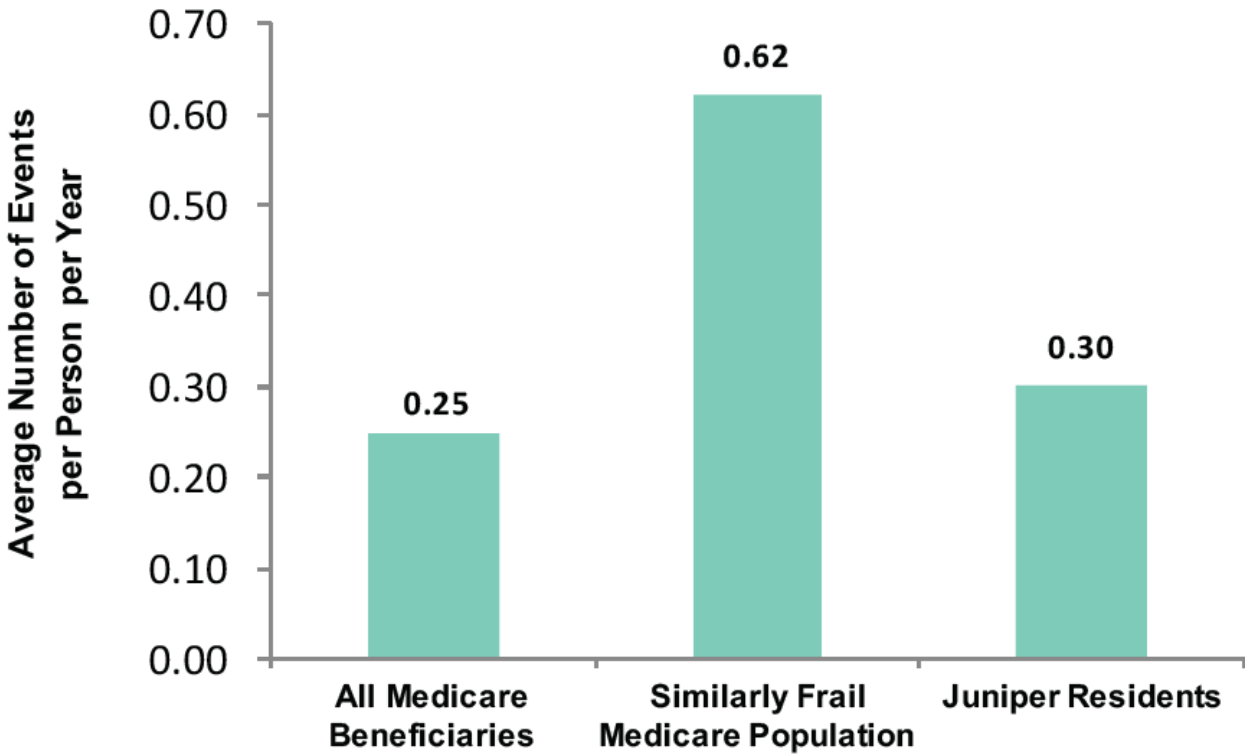
"Frail Medicare Population", population similar to Juniper residents, has inpatient and total spending > 2X typical Medicare beneficiary.

When compared to a similarly frail population living in the community or in seniors housing communities overall, **Juniper's hospitalization rate was about 50 percent lower**.

Spending Two Times Higher for Similarly Frail Medicare Population



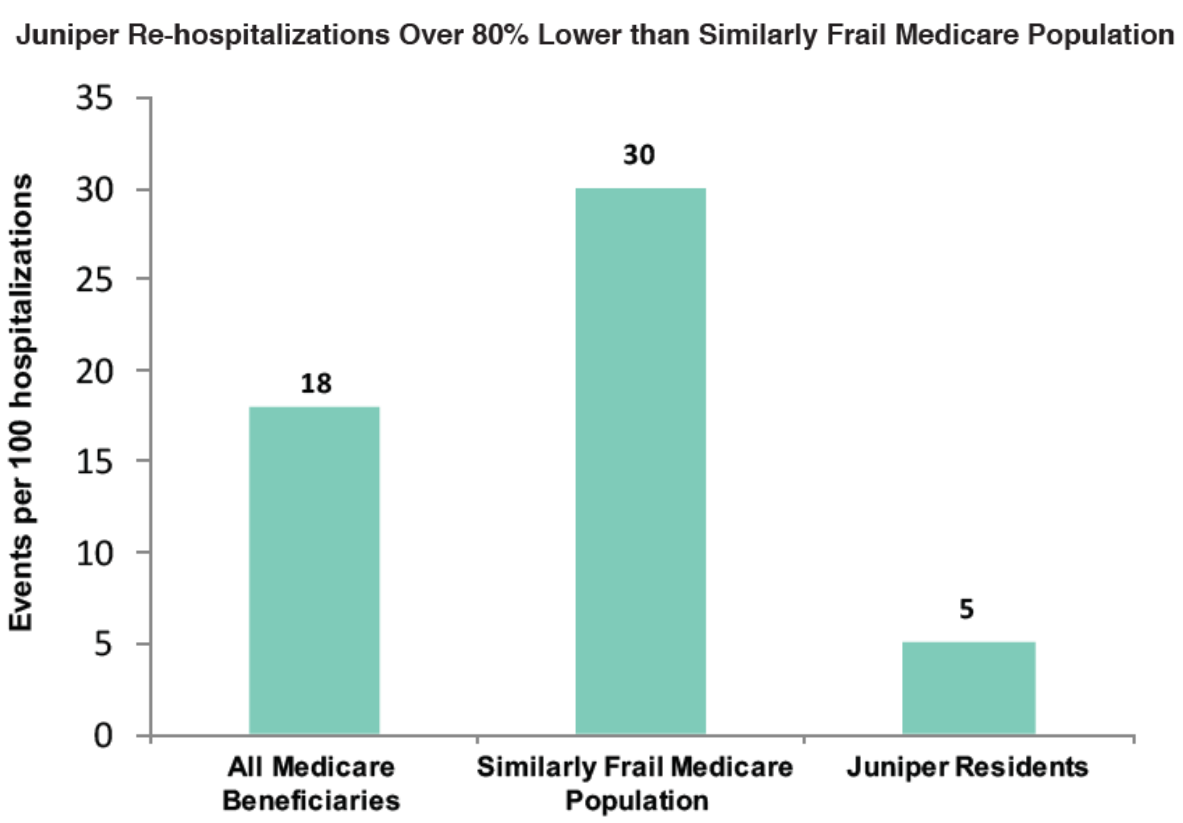
Juniper Residents' Hospitalization Rate Half the Similarly Frail Medicare Population

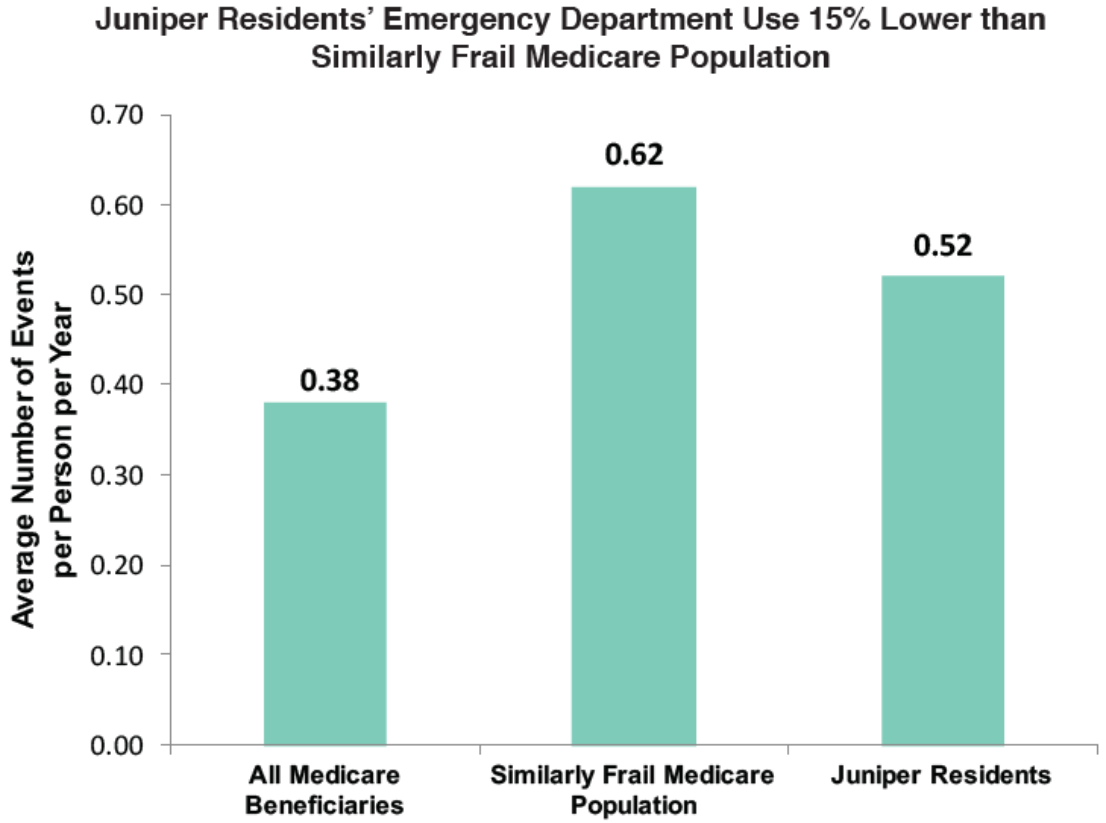


Findings from Anne Tumlinson, MMHS and Lynne Katzmann, PhD, March 2017 study of Juniper Communities integrated care team model "Integrated Care in Seniors Housing that Meets the Triple Aim"

Juniper's inpatient **re-admission rate > 80% lower** than comparison "Frail Medicare Population".

Juniper's **ED utilization 15% lower** than comparison "Frail Medicare Population".





Benefits impact:

- **Residents**
- **Families**
- **ALF staff**
- **Provider**

ALF Clinically Integrated Care Model

Provider Care Team

- **Medical**
  - Physician
  - Nurse Practitioner
- **Behav-ioral**
  - Psych NP
- **Care Coord-inator**
  - Licensed Nurse

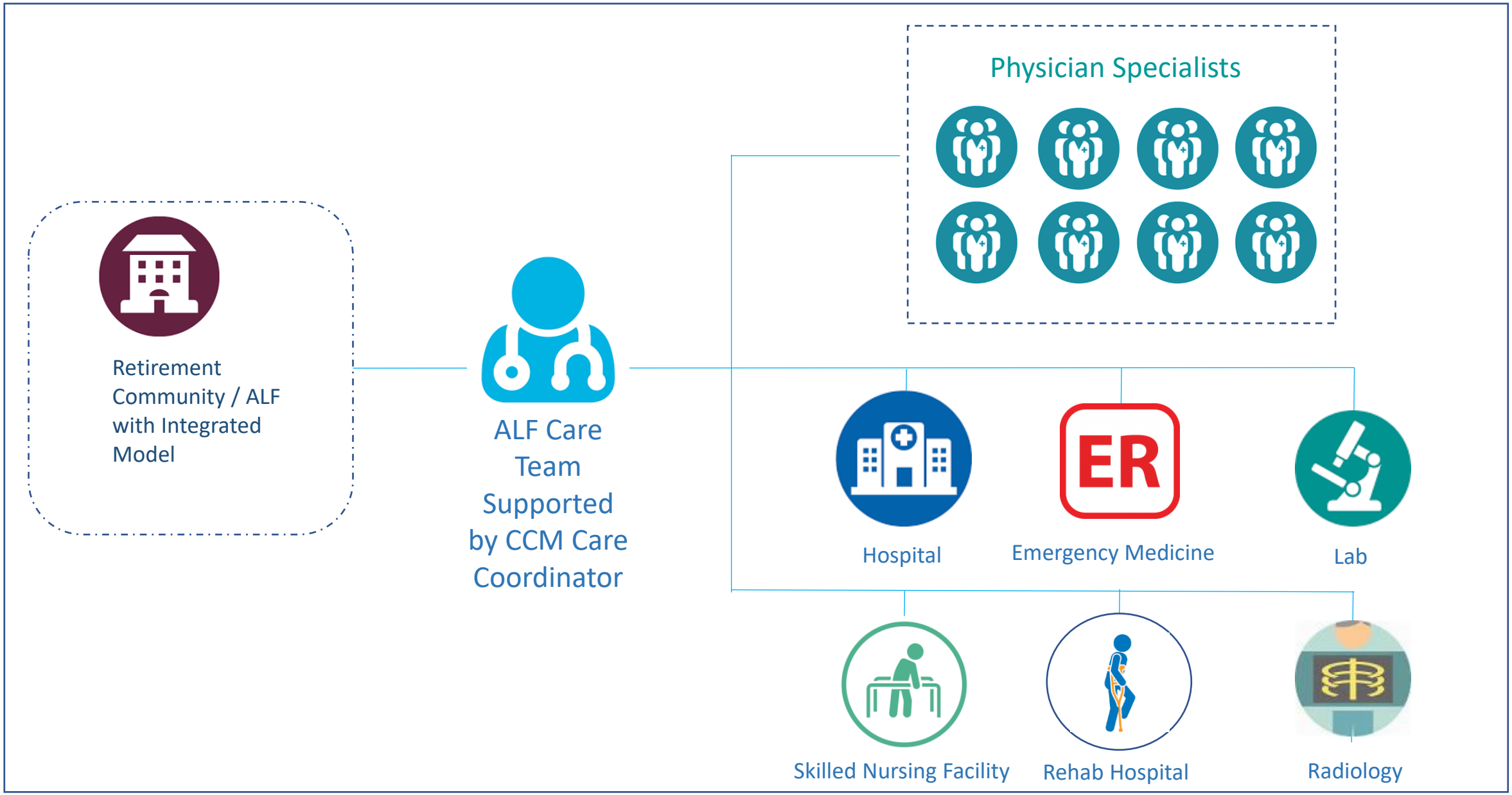
Integrate

Share, align systems and processes

Key ALF Health Care Services

- Rehab
- Home Care
- Pharmacy
- Lab
- Diagnostic Testing

Integrated Care with External Network



Benefits of Organized ALF Integrated, Coordinated Care Team Model

- Decreases ALF resident **acquisition costs** and increases ALF / retirement community resident **retention** (coordinated care model demonstrated 8 months longer retention*)
- Lower hospital and SNF **utilization^**
- **Takes burden off ALF staff and family** to provide coordination and management of care
  - Relieves ALF and family members of shouldering healthcare management duties alone
  - Improves resident experience and health outcomes
  - Promotes disease self-management – Team helps resident stay educated, well-informed, and maintain close communication with integrated care team members
- **Provider care plans** (coordinates on-campus and external community care providers)
  - Implementation of clinical care processes using evidence-based practice guidelines, pathways, protocols
  - Increased communication – Team-members engage in routine information sharing and communication, attend standing meetings, and are accountable for their performance
  - Coordinated care – Key information is shared among internal/external providers including lab results, medications, allergies, life-impacting events, educational needs, resident / family goals, and health and wellness objectives
  - Coordinated wellness and prevention program

*Optum, 2019-2020 IESNP results

^ Anne Tumlinson, MMHS and Lynne Katzmann, PhD, March 2017 study of Juniper Communities integrated care team model "Integrated Care in Seniors Housing that Meets the Triple Aim", 2017.

Chronic care management (CCM) is a critical component of **primary care** that contributes to better outcomes and higher satisfaction for patients.

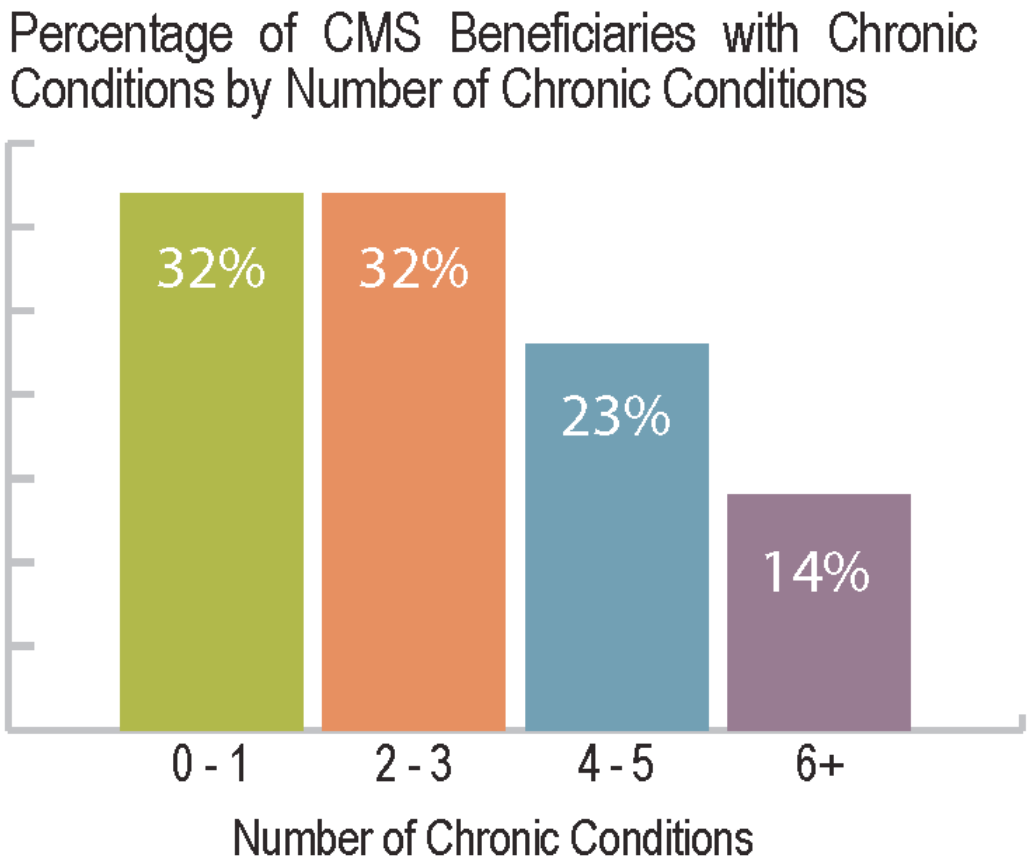
The Centers for Medicare & Medicaid Services (CMS) recognizes that providing CCM services takes **provider time and effort**.

CMS established separate payment under billing codes for the additional time and resources you spend to provide the **between-appointment help** many of your Medicare and dual eligible (Medicare and Medicaid) patients need to stay on track with their treatments and plan for better health.

Centers for Medicare & Medicaid Services, "CONNECTED CARE TOOLKIT: Chronic Care Management Resources for Health Care Professionals and Communities", Department of Health and Human Services, 2017.

Why CCM?

- Offers more centralized management of patient needs
- Extensive care coordination among clinicians
- Reduces hassles for clinicians, and the patients and caregivers.



Nurse Care Coordinator Role & CCM

Chronic Care Management (CCM) is a Medicare benefit. The program provides services of a Care Coordinator between appointments with the Physician and Nurse Practitioner.

Between onsite, in-person visits your Physician and Nurse Practitioner will order medications and other services. Beyond that, with CCM, **responsibility for coordinating between visit tasks is handled entirely by the Care Coordinator**. The Nurse Care Coordinator will coordinate services with:

- Community clinical staff
- Primary care physician
- Nurse Practitioner
- Behavioral health
- Home health
- Outpatient rehab
- Pharmacy
- Lab
- X-ray
- Ambulance
- Dental
- Podiatry
- Optometry
- Specialists
  - Cardiologist
  - Pulmonologist
  - Neurologist
  - Urologist
  - Dermatologist
  - Psychiatrist
- Emergency department
- Hospital
- Skilled Nursing Facility
- Rehab Hospital
- and more.

In addition to coordination of services listed above, with your CCM benefit you get the following:

- A care plan is developed with the resident to better manage the resident's chronic conditions.
- The Nurse Care Coordinator educates the resident on chronic conditions and reviews medications and treatments related to the conditions.
- The Nurse Care Coordinator is available by phone to respond to resident questions.
- The Nurse Care Coordinator is a resource for senior living community staff that identify changes in resident condition.

CCM criteria for Medicare beneficiary to receive services

Care coordination **services done outside of the regular office visit** for **patients with multiple (two or more) chronic conditions** expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These services are **typically non-face-to-face** and allows eligible practitioners to bill for care coordination services per month.

Chronic care management services may include:

- At least 20 minutes a month of CCM services
- Personalized assistance from a dedicated health care professional who will work with the patient to create a care plan
- Coordination of care between patient's pharmacy, specialists, testing centers, hospitals, and more
- 24/7 emergency access to a health care professional
- Expert assistance with setting and meeting patient's health goals

Medicare and Medicare Advantage began paying for CCM services separately under the Physician Fee Schedule (PFS) in 2015.

Centers for Medicare & Medicaid Services, "Chronic Care Management Services", Medicare Learning Network, MLN909188 March 2022.
Centers for Medicare & Medicaid Services, "Connected Care: The Chronic Care Management Resource", 2021.

CCM Program Experience Feedback

ALF Nursing Staff

- Improved communication and information sharing
- Improved timeliness of services that rely on the physician practice for orders and referrals
- Less stress on staff to follow-up and coordinate care
- High family satisfaction particularly from families with frequent calls and inquiries

Residents and families

- Relieved that they do not need to coordinate services especially outside services and providers
- High level of satisfaction having one point of contact for health care questions
- More timely follow-up to questions and concerns related to the physician practice itself and related to the services that the CCM Care Coordinator is facilitating

ALF Sales and Community Relations

- Additional service support of CCM Nurse Care Coordinator provides a competitive advantage
- Hospital referral source confidence in ALF capabilities to treat in place.

- **Identify preferred services and providers that you recommend to your residents**
- **Ask preferred services and providers to collaborate and integrate systems and processes, including the physician service Care Team**
- **Hold physician practice accountable for implementing a CCM program and care coordination**

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