Community Care Hub Spotlight

Partnership between an Area Agency on Aging and a Primary Care First Practice

Addressing health-related social needs (HRSNs) requires partnership between health care systems and community-based organizations (CBOs). CBOs can play a strategic role in helping health care systems address HRSNs. They have longstanding relationships with community members providing health and social service information and referral, promoting health and well-being through service coordination and delivery, and reducing social isolation.

In Michigan, the Region IV Area Agency on Aging (AAA) and Corewell Health South began working together to address a growing community need. They have a shared vision to integrate social care into the delivery of health care and unify the efforts of both medical and home and community-based organizations to improve health and reduce health care costs for older adults with complex care needs. A partnership was formed to pilot the integration of medical and social needs to:

- Improve health through reduced emergency department and inpatient utilization
- Drive care to the primary care setting
- Improve patient engagement and experience
- Expand connection to a network of community-based services and resources via the AAA hub
- Help patients to maintain independence
- Support caregivers

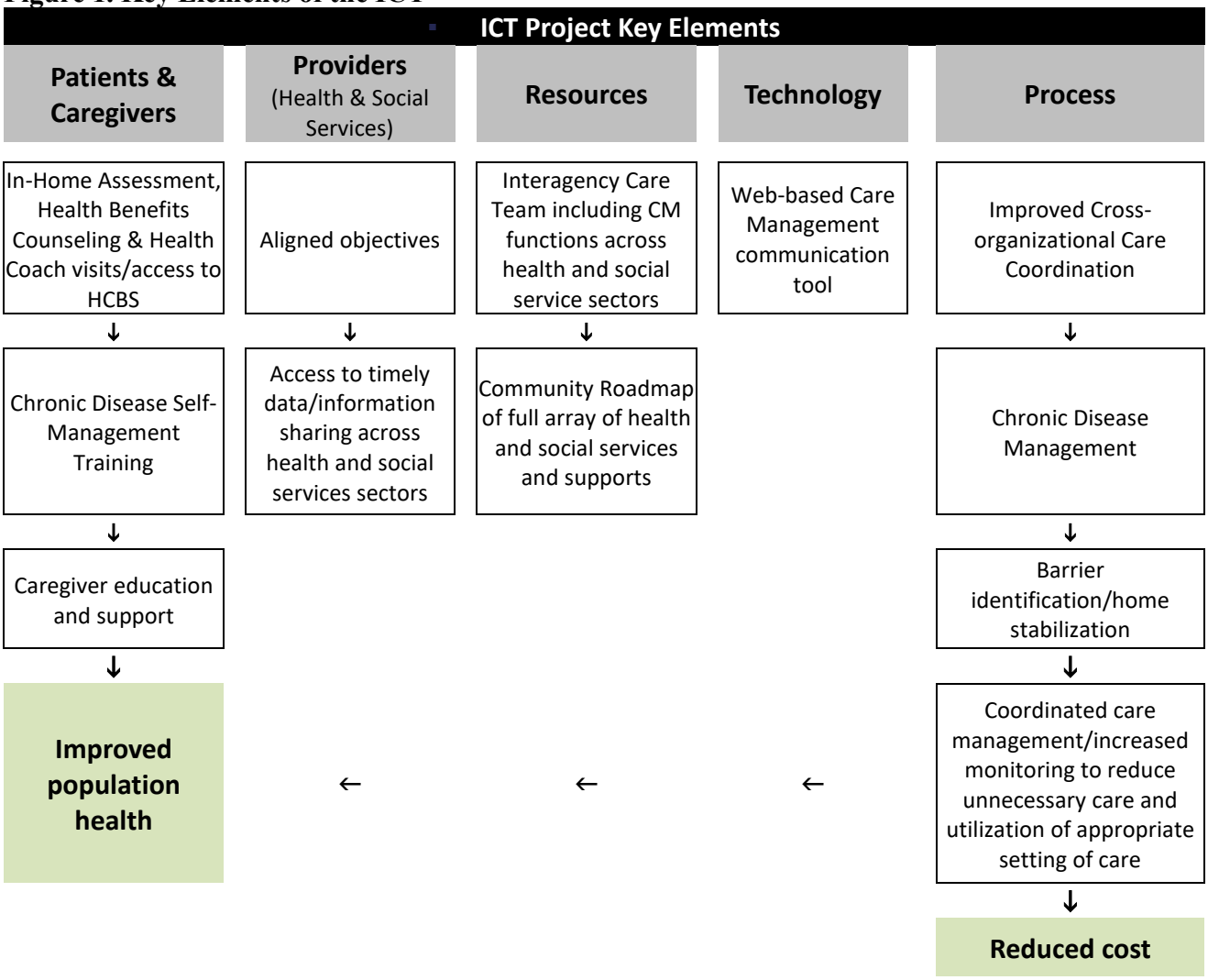
Opportunity

The Region IV AAA and Corewell Health South developed a partnership to mitigate a common issue: older adult who have multiple chronic conditions experience some of the worst health outcomes in the region, often resulting in increased disability, institutionalization, and avoidable death. Cross-organizational meetings occurred bi-weekly to develop a pilot to measure the impact of an interagency care team (ICT) model.

Best Practice Model

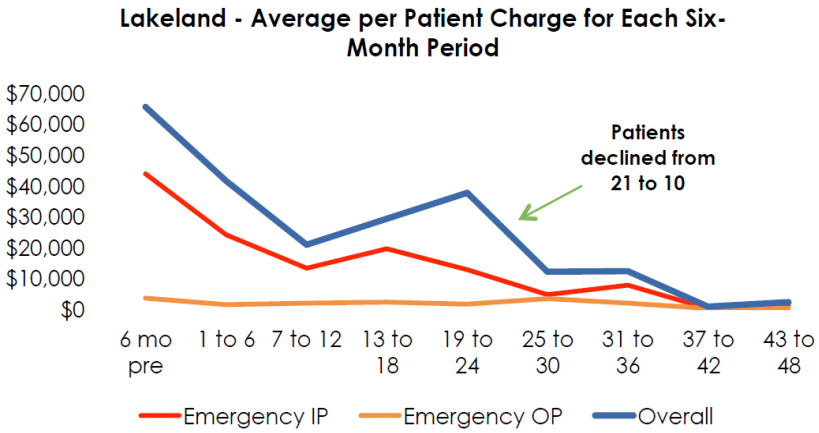
To resolve barriers faced by community members, Corewell Health and the Region IV AAA tapped into a network of CBOs. An ICT model was developed (See **Figure 1**) which includes an in-home assessment, health benefits counseling, and a health coach to connect patients to home and community-based services and training on chronic disease self-management. The AAA serves as the hub for access to the network of CBOs to meet identified HRSNs. An added value is support for caregivers, blending what patients need within the context of the families and communities that support them. The ICT model goes beyond coordination to action aimed at improving population health and reducing costs.

Figure 1. Key Elements of the ICT



Impact

Pilot results reflect that the ICT model resolved 91% of barriers (e.g., caregiver burnout, transportation, home accessibility, etc.) patients faced through coordination and connection to a network of community resources, services, and supports. Six months post ICT intervention, patient engagement increased by 86%, cost of care decreased by 55%, and primary care visits increased by 19%.



Sustainability

One key to success is sustainability through the establishment of a payment model. In 2012, the partnership began through bi-weekly cross-organization meetings that led to expansion through funding from four local and one state foundation. Initial funding was used for services, evaluation, and development of a scalable payment model. Contracts were executed with a rural health clinic and a Primary Care First practice in 2019, with a focus on distinct fee for service Medicare billing codes (**Figure 2.**) Building on early successes, Michigan Region IV AAA and Corewell Health intend to develop a value-based payment model for 2024 that prioritizes shared saving and shared risk.

Figure 2. Fee For Service Billing Codes

Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	▪ Patient enrolled in person ▪ Systematic assessment & care planning personally performed by the billing provider ▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit
CPT 99490	Standard CCM	▪ 20+ minutes of care management outside of office visits performed by clinical staff ▪ Care plan established and regularly reviewed
CPT 99439 (New in 2021)	Non-complex Add-on	▪ Additional 20 minutes of "non-complex" CCM ▪ Reportable up to 2x per month (after 99490)
CPT 99487	Complex CCM	▪ 60+ minutes of care management outside office visits ▪ Care plan created and/or significantly revised
CPT 99489	Complex Add-on	▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case

Why does this model work?

- ✓ Supports providers and patients to prioritize care goals and create a plan to address chronic disease
- ✓ Utilizes subject matter experts on health-related social needs to achieve disease related goals
- ✓ Provides a proactive and tailored approach to address complex needs
- ✓ Improves patient and caregiver satisfaction
- ✓ Increases use of home and community-based services and reduces inpatient and emergency department use, nursing facility admission, and outpatient services
- ✓ Increases touch points with patients
- ✓ Reimburses team for non-face to face work (e.g., tracking referral follow-up)
- ✓ Improves quality outcomes

Lessons Learned

- Identify health system champions – physician and other health system leadership with understanding of the impact of social care on health outcomes and knowledge of and influence within the larger health system can socialize the vital roles of CBOs and social care clinicians, foster trust, bridge organizational and cultural gaps, and reduce barriers to needed resource allocation.
- Build a shared vision and culture – developing a strategic work plan that intentionally builds a unified "we" and shared "why" will engender trust, synergy, and resilience to challenges.
- Be patient and persistent – systems are complex; regulations, entrenched practices and care models, multiple stakeholders, and varying interests will all impact the team's work plan and progress.
- Demonstrate and celebrate success though data and impact stories – sharing measurable outcomes, including financial return on investment and compelling stories of their impact, inspires confidence in the model of care, informs decision-making, and becomes a powerful tool for advocacy.
- Aim for structural linkages rather than just referral relationships – alterations in the framework, organization, and design of systems will ensure sustainability beyond personnel transitions and organizational shifts.

For More Information

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