ADVOCATES FOR COMMUNITY HEALTH
United for Health and Innovation

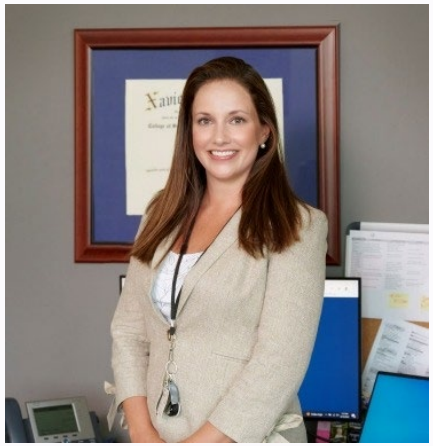
ACH Emerging Issues Webinar:
Helping FQHCs Prepare for an Aging Population

April 3, 2024

12:00 p.m. – 1:00 p.m. ET

This webinar is being recorded. We will begin shortly.

Speakers



Suzanne Bailey, PsyD
Chief Operating Officer
Cherokee Health Systems

Steve Brennan
Senior Policy Director, Healthcare Delivery & Access
United Healthcare Community & State

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health
Moderator

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Vice President & Chief Strategy Officer
San Ysidro Health

Steve Brennan

United Healthcare Community & State

Helping Community Health Centers Better Serve an Aging Population

Steve Brennan

April 3rd, 2024

United Healthcare®

UnitedHealthcare & Community Health Centers

Critical Providers for UnitedHealthcare Members

>28%

Of Medicaid Members served by CHCs

1,816 CHCs (includes FQHCs, RHCs and Look-Alikes)

are in our UnitedHealthcare Network

$100m

are in our UnitedHealthcare Network

Areas of Focus

Collaborations

- FQHC Advisory Board
- Redeterminations

Capacity Building

- Transformation Pathways
- Access to Care Pathways
- Entrepreneur Challenge

Enhanced Service Model

- Tools for technical needs
- Tools for community need
- Reimbursement strategies
- Progress towards value-based care
- Opening additional revenue streams

FQHC Market
Strategy – In Progress and Future

The Role of C&S

FQHCs represent an outsized role in the C&S network; C&S has an opportunity to differentiate itself by partnering with FQHCs through a purpose-built model.

Goal

Partner in the design and communication of this model bringing the right and most impactful of UHG's resources to FQHCs to help them perform at their best.

The main features of which are:

I. **FQHC Operational Center of Excellence**
    I. Streamline the operational basics, and putting the focus on delivering care

II. **Broader CHCs – UHC Partnerships**
    I. Find ways to partner not only with CHCs as organizations but with the individuals directly serving our members

III. **Helping provide a better care delivery experience**
    I. Pilots geared towards supplying tools and aggregation to assist in technical and community needs, redefining reimbursement strategies, and promoting progress towards value-based care opening additional revenue streams.
    II. Leveraging Clinical Delegation to take on more responsibility of member management opening additional revenue opportunities
        I. High Risk/Complex Care Management Delegation
    III. Re-Tier ACOs providing additional UCS resources to ACOs wanting to partner
    IV. Address PCP Assignment/Attribution discrepancies

Goal of letting FQHC clinicians spend less time on administrative duties and more time seeing patients. As a trade off, by increasing FQHC capacity more patients can be seen at these preferred providers.

By the Numbers…

- The United States (U.S.) Census Bureau projects a rise in the adult population age 65 and older from 54.1 million to 80.4 million by 2040, and another dramatic increase to 94.7 million by 2060
- While the current percentage of patients over 65 who receive care at FQHCs is usually <10%, the FQHCs are expected to play an ever-increasing role in the primary care safety net for older adults.(1)
- 2018 Prevalence of Chronic Diseases for Those 60 and Older in the HRS Chronic Condition Prevalence (% with Health Treatment Burden)(2)
    1. Hypertension 68.7%
    2. Arthritis 68.2%
    3. Diabetes 31.2%
    4. Heart Disease 30.1%
    5. Cancer 19.1%
    6. Depression 35.9%
    7. Lung Disease 12.7%
    8. Stroke 11.5%
    9. Alzheimer’s /Dementia 2.6% 6.7%

Increasing Older Patient Population Brings Expanding Set of Service Needs

Older Adult Service Needs

- Longer appointment slot
- Increased need for physician visits, including from internal medicine physicians and geriatricians
- Chronic disease management
- Care management services
- Access to aligned specialty services, podiatry, cardiology, physical therapy, endocrinology, gastroenterology
- Aligned ancillary services, such as pharmacy and imaging
- Behavioral health services
- Dental services
- Polypharmacy / medication reconciliation
- Targeted support, such as transportation, isolation-reducing services, partnership with housing programs

United Healthcare Initiatives to Support CHCs' Serving Aging Patients

- Development and implementation of Medicaid Value-Based Payment models nationally that provide a Per Member/Per Month payment structure and incentives to support PCPs provide care management, care coordination and serving patients with complex needs;
- Financial support for CHC best practices – Entrepreneur Challenge winner Morris Heights Community Health, Bronx, NY: Age Well program to increase connection and access for seniors –HRSNs, linking community resources to improve the health of seniors in the community;
- UHC in New Jersey recently submitted a proposal to partner with Community Health Centers in Cumberland and Salem counties to deploy Community Health Workers (CHWs) to serve patients – many of whom are elderly - who are diagnosed with chronic illness and/or medical conditions, such as hypertension/heart disease, diabetes, mental illness and substance abuse.

Vernita Todd, MBA, FACHE
San Ysidro Health

Serving our Aging Populations

Advocates For Community Health Webinar

April 3, 2024

Kevin Mattson, President & CEO
Vernita Todd, Vice President, Senior Health Services

SAN YSIDRO HEALTH

About San Ysidro Health

Why San Ysidro Health

At San Ysidro Health, *patient-centered* is our way of saying that patients are our top priority.

www.syhealth.org

Patients

145,000!
20 Clinics
34 Program Sites

PCMH

National Committee for Quality Assurance

Workforce

Internal Medicine Residency
Family Medicine Continuity Clinic
Pediatric Dentistry Residency
AT Stills Medical School

Network

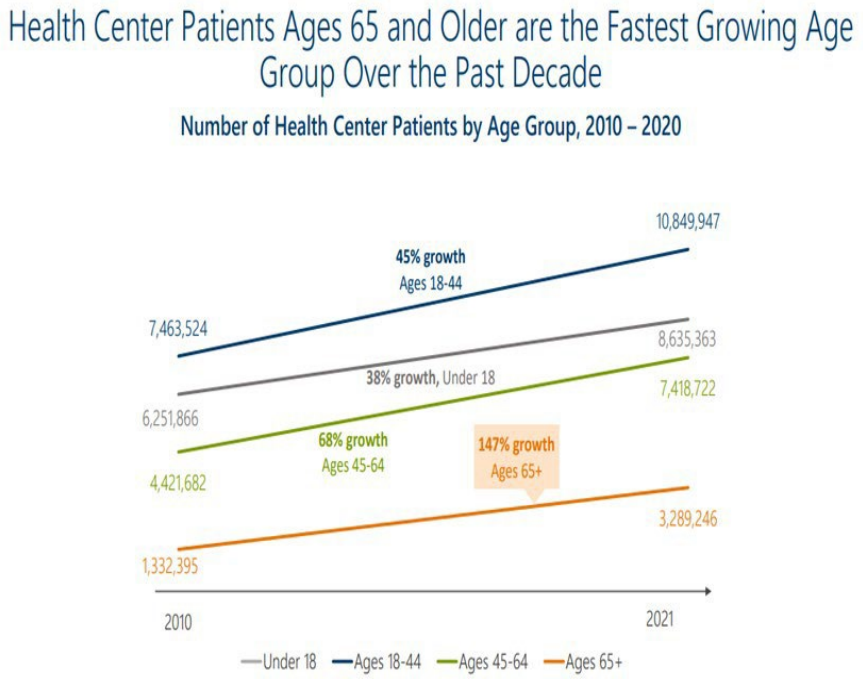
20th largest FQHC in the Nation based on patients served *(n=1,370)*

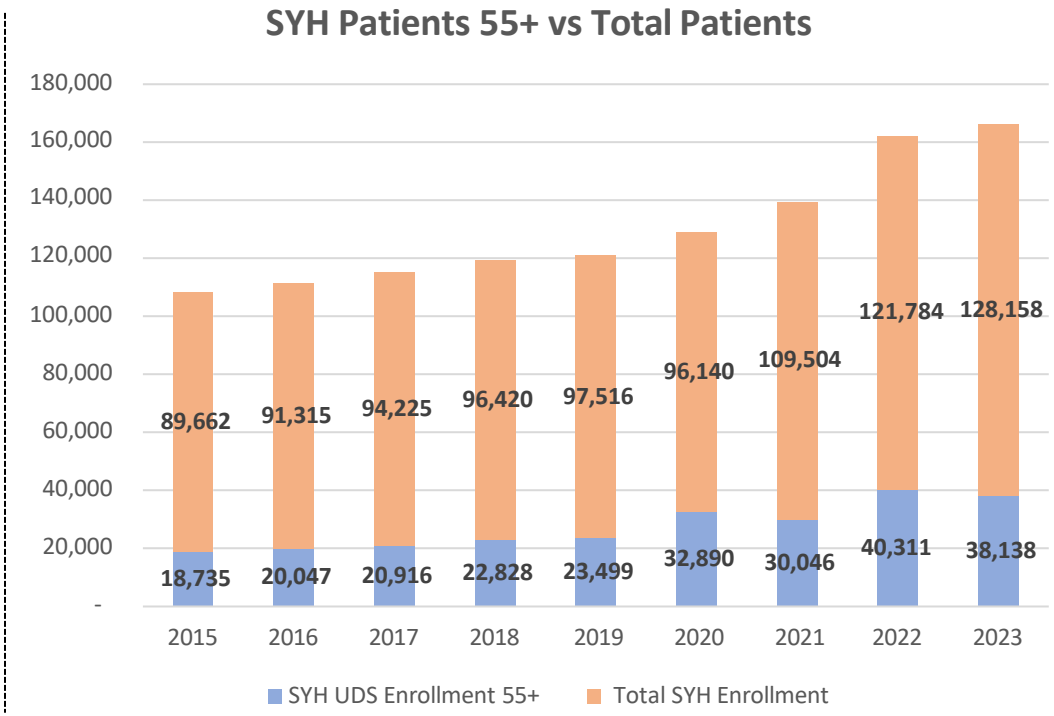
2nd largest by budget

Team

2,700 Employees
250+ Provider Staff
MDs, Dentists, Psychologists, Nurse Practitioners

Our Patients are Aging with the Movement





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Expanding Care for Seniors at San Diego PACE

- Opened in 2015
- Currently Serving 2,820 Seniors
- Four PACE sites (one in development)
- Covers 114 San Diego County zip codes

Why The Model Works

TRUSTED PARTNERS

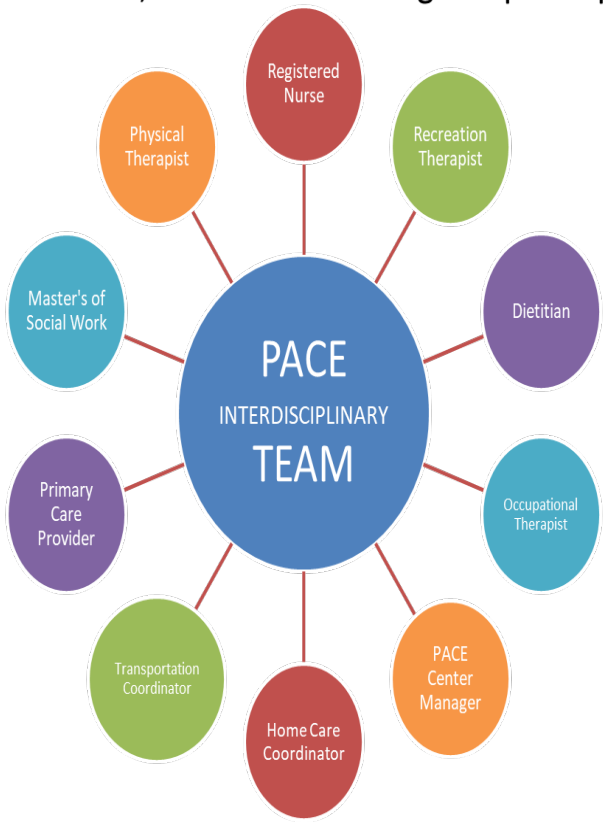
- FQHCs have robust and comprehensive care delivery systems already developed
- FQHCs take a population health focus to quality
- FQHCs understand the importance of SDOH on participant care
- FQHCs are known to the patients and community stakeholders

INTEGRATED CARE

- FQHCs have integrated care models and health records
- FQHCs are Patient Centered Medical Home *(critical for PACE)*

PACE Interdisciplinary Team

IDT assess need, deliver and manage all participant care



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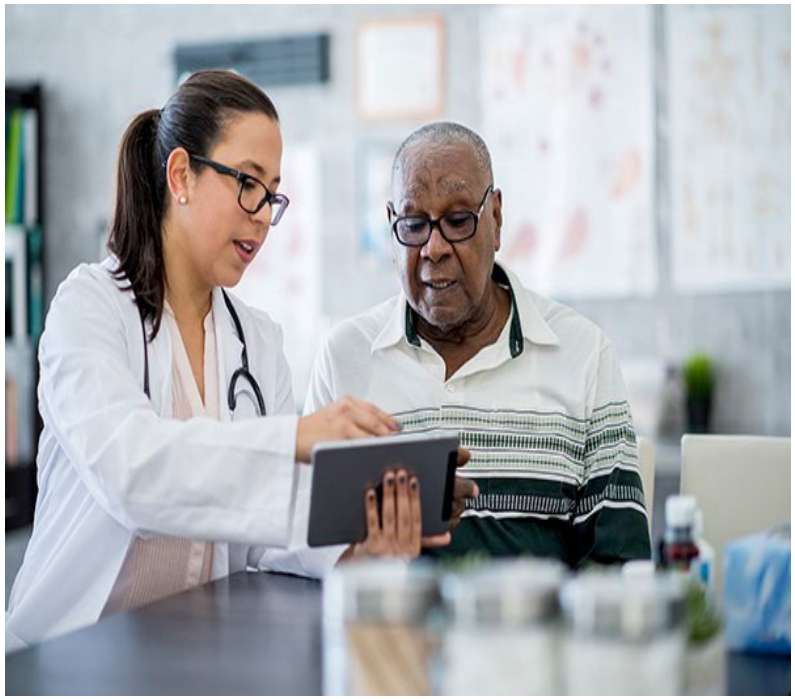
Retaining Aging Populations beyond PACE



Senior Needs are different and should be addressed accordingly to make seniors feel connected to their medical home:

1. Longer Appointments
2. More Medication Management
3. Caregiver Assistance
4. Coordination of Appointments
5. Socialization Needs
6. Quiet, Easy, Relaxing

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SAN YSIDRO HEALTH
Thank you!
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Learn more at www.syhealth.org or www.sandiegopace.org
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Dr. Suzanne Bailey
Cherokee Health Systems

Cherokee Health Systems' Age Friendly Health Care Continuum

Suzanne Bailey, PsyD
Chief Operating Officer
Cherokee Health Systems

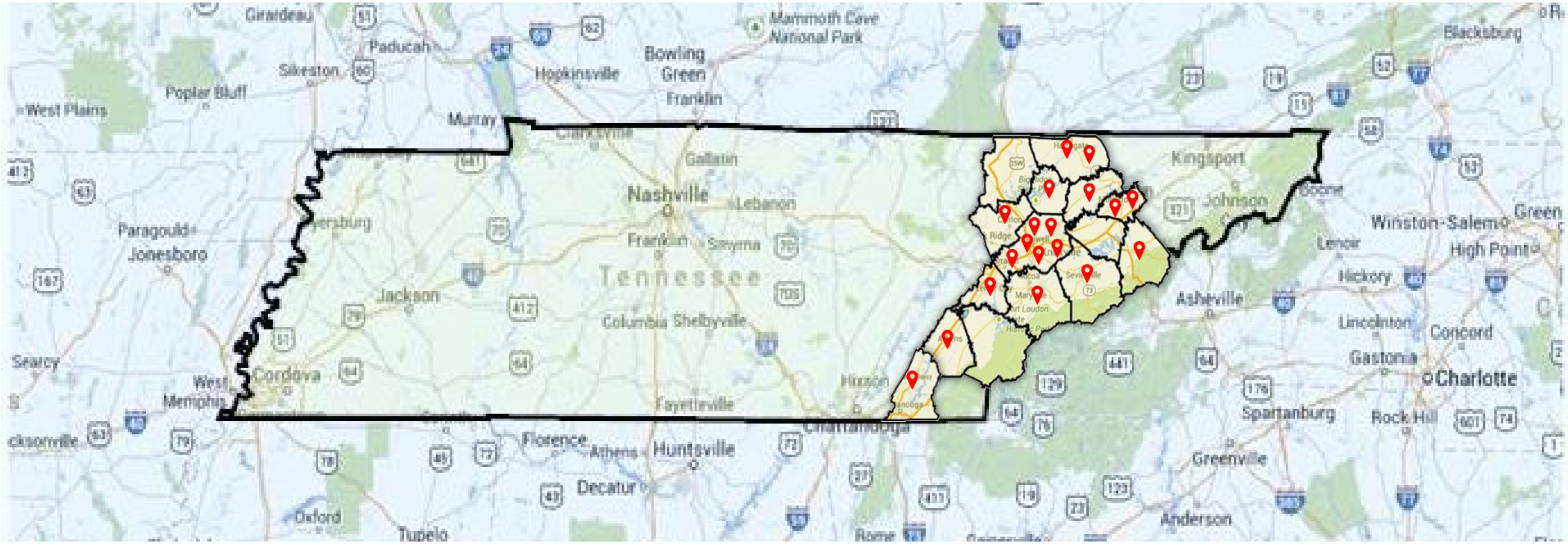
Cherokee
HEALTH SYSTEMS

Together...
ENHANCING LIFE

Cherokee Health Systems Snapshot

- **History:** Established in Morristown, TN in 1960
- **Federal and State Designations:** Licensed Community Mental Health Center, Licensed Alcohol and Drug Treatment Facility Federally Qualified Health Center,
- **Service Area:** 13 counties in 3 distinct geographic service areas including East Tennessee, Chattanooga, and Memphis
- **Total Sites:** 20 physical sites, 1 mobile clinic
- **Patient Volume:** 67,000+ total patients in a year. On a typical workday, 1,800+ patients receive a clinical service at CHS
- **Services:** Behavioral Health (psychotherapy, psychiatric medication management, case management, peer recovery/support/wellness, day treatment, school services), Substance Use Disorder Treatment (including MAT, IOP, EOP), Pediatric and Adult Primary Care, OB/GYN, Dental, Optometry, Pharmacy, & Community Outreach
- **Staff:** 648 employees (175 providers)

Map of Service Area



Cherokee
HEALTH SYSTEMS

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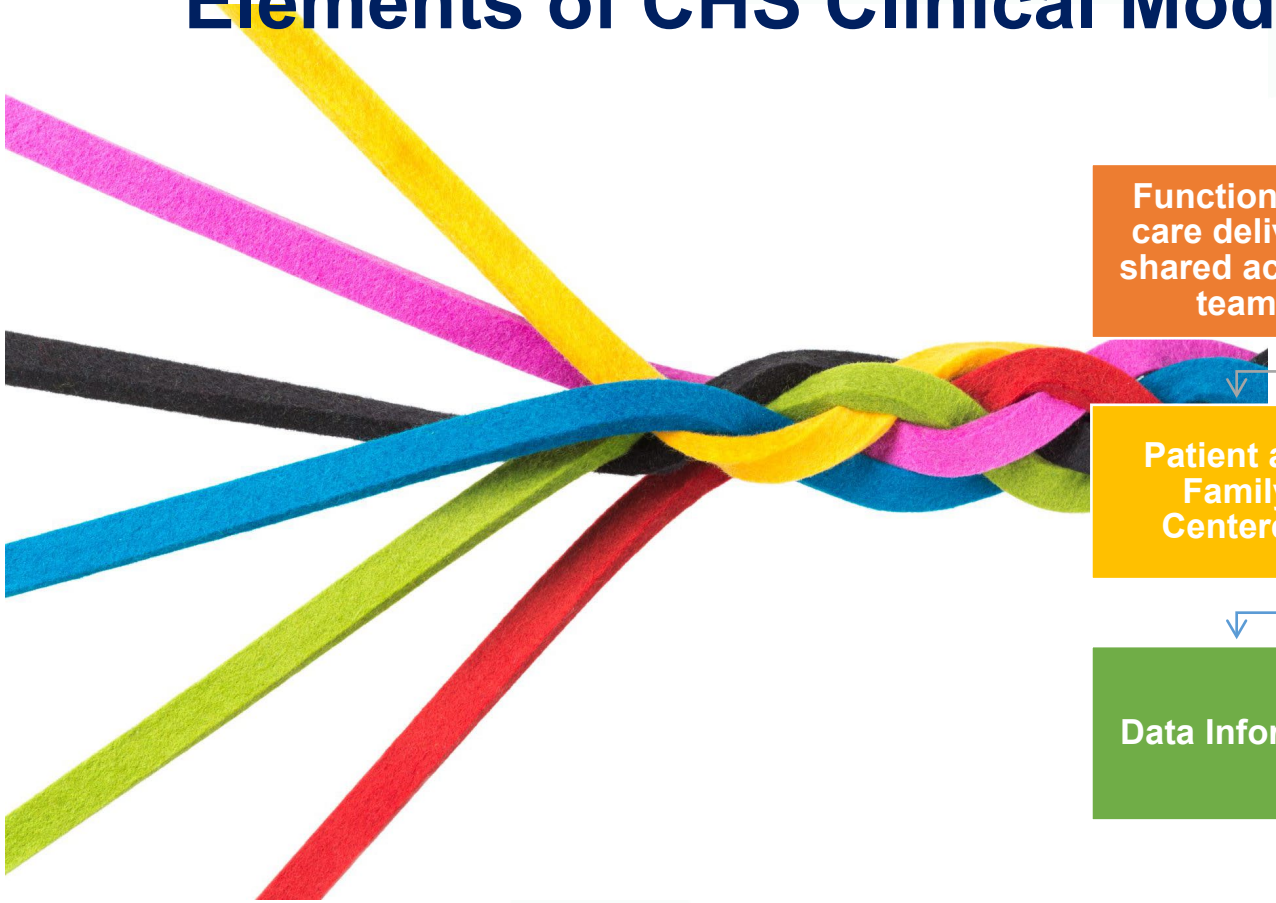
Elements of CHS Clinical Model



- Functions of care delivery shared across team → Integrated Care team
- Patient and Family Centered → Communication and care coordination
- Data Informed → Cultural Safety

Age Friendly Clinical Model

- Integrated care addresses physical, emotional cognitive, and environmental health factors.
- Aligned with IHI 4 Ms:
  - What Matters
  - Mentation
  - Mobility
  - Medication
- Recognized as Participants and Committed to Care Excellence

Continuum of Care

Cherokee HEALTH SYSTEMS

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Services and Programs

- Medicare Wellness Visits
- Medication Therapy Management (MTM)
- A Matter of Balance Groups
- Dementia Friends

Q & A

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