

## PRIMARY CARE MODERNIZATION

# Community Purchasing Partnerships

## ELECTIVE CAPABILITY

Primary care practices contract for home and community-placed services that extend the reach of primary care to better meet the health needs of diverse communities, address social determinants of health (SDOH), or fill gaps in services.

DRAFT

## HOW CARE WILL IMPROVE

### CONSUMERS CAN...

- Get help from your doctor's office to find community resources to help you meet your health goals
- Get help adopting a healthy lifestyle from organizations in your town or neighborhood
- Get help managing your chronic illness in your home or your community, possibly with others who have similar health problems
- Connect to services such as early intervention or community care programs that are important to getting and staying healthy



### PRIMARY CARE TEAMS CAN...

- Engage community resources such as community centers, churches, barbershops, and schools to undertake population health interventions
- Offer connections to community organizations that can more effectively engage and support patients experiencing barriers to preventive and chronic illness care
- Enhance your ability to manage patients with complex care needs by partnering with community care teams or community paramedicine providers
  - Reduce the burden on the primary care team by creating effective solutions for addressing health disparities and populations at risk for poor outcomes



## PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION



Constance is eighty years old and has struggled with her health since complications from a hip replacement two years ago. She manages living alone at home but is not very mobile and driving is uncomfortable.



Constance wakes up one night in extreme pain. She has felt like she has to go the bathroom all the time for a few days. Not wanting to go to the Emergency Room, she calls her primary care's hotline to speak to a nurse on call.



The nurse dispatches a community paramedic, contracted with the practice, to her house. The paramedic takes a urine sample and tests it with a portable kit. He calls the nurse to confer on results and treatment.



After conferring with the nurse, the paramedic gives Constance an injection of antibiotics to treat a urinary tract infection and a pill to relieve her symptoms. The next day, Constance's primary care provider calls to check on her.



# HOW



## Care Team and Network Requirements

- Identify service gaps and needs for community-placed services
  - Evaluate performance on health promotion, preventive screening, chronic illness management, care transitions, and management of patients with complex needs
  - Segment evaluation based on population characteristics such as race, ethnicity, language preference, health literacy, SDOH risk, sexual orientation and gender identity status, and disability status
- Contract for community-placed services to address identified service gaps, such as evidence-based navigation and coordination, early intervention and secondary prevention, chronic illness self-management, care management for patients with complex health needs, and in-home support for patients as needed
- Clinical protocols and analytics to support identification of patients that require these services
- Referral management protocols including determining whether individuals were successfully linked to and served by community-placed services
- Outcomes tracking including the impact on patient experience, healthcare outcomes and cost



## Health Information Technology Requirements

- Electronic health record (EHR) that captures population characteristics
- Analytics that enable performance analysis with respect to such characteristics
- EHR configuration or software to support referral management with respect to community-placed services
- EHR configuration and analytics to support outcomes measurement
- Consent and confidentiality management solution

## MEASURING IMPACT

### ✓ Patient Experience

- Improved provider communication and medical home ratings such as "explained things in a way that was easy to understand" and "asked you if there were things that make it hard for you to take care of your health"

### ★ Quality

- Improved preventive care (e.g., cancer screening, immunizations)
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

### \$ Cost

- Reduced emergency department visits and hospital admissions
- Averted or reduced length of stay in skilled nursing facilities with coordination of home-based supports

### ↗ Access

- Faster, more convenient connection to local, culturally competent health resources

## IMPROVING HEALTH EQUITY

Patients experience barriers to care that result in health disparities. Access to culturally appropriate community-placed care can reduce these disparities in the following ways:

✓ **Community-placed providers can address health and preventive care needs** in the home or in a convenient, culturally appropriate and trusted community setting.

✓ **Community-placed providers can better address social and environmental risks**, language preference and health literacy gaps.



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## ADULT COMMUNITY PURCHASING PARTNERSHIPS



### CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services  
 [See also: Community Integration to Address Social Determinants]



### HEALTH NEIGHBORHOOD

Arrangements With Community Placed Services



### ONGOING COMMUNICATION ABOUT PATIENTS

#### TYPE OF SERVICE

Community Placed Navigation or Linkage Services

#### EXAMPLES OF MODELS



Health Leads or Project Access

Early Intervention and Secondary Prevention Services



Community Meeting Place Approach

Chronic Illness Self-management Services



Prevention Services Initiative

Complex Care Coordination for High Risk Patients, Often with SDOH Needs



Community Care Teams, Leeway Community Living

Support for Patients with Acute or Chronic Medical Risk at Home



Mobile Integrated Health/Community Paramedicine