AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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American Geriatrics Society Response - HHS Initiative to Strengthen Primary Care
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The AGS appreciates the opportunity to provide perspectives and expertise on effective models of care and methods for improving primary care for older individuals, especially those with multimorbidity. We have reviewed the National Academies of Sciences, Engineering, and Medicine's report, *"Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021),"* just as OASH has, and note that the recommendations therein are endorsed by our organization. The AGS is a multidisciplinary organization and our patients require services from medical professionals (including mental health and substance use), social services, and the community. Geriatrics healthcare professionals come from fields that are primary care first (e.g., general internal medicine, family medicine, advanced practice nursing) and focus on care of those with comorbidity and functional impairment. Therefore, we highlight the need for effective teams. This requires team-based training, payment for team-based care, and communication technologies that links a primary medical care site with other medical settings of care and community-based services. This will not occur without an effective payment model for training and primary care, which only exists today in pilots or demonstrations with few exceptions. The science of better primary care for our and all patients requires research and dissemination. The commitment to these goals will require a central organizing entity that receives advice from a body that has representation including geriatrics professionals, patients, and caregivers/family.

Successful models or innovations that help achieve the goal state for primary health care:

A recent article in the *Journal of the American Geriatrics Society* explored the common components of models of care in geriatrics when caring for older adults with care complexity. The article, spearheaded by the Clinical Practice and Models of Care Committee of the AGS, defines care complexity in older adults, reviews healthcare models and the most common components within them, and identifies potential gaps that require attention to reduce the burden of care complexity in older adults. We urge CMS to review the article. Also of note is that we did not determine if the models reviewed had been tested in underserved communities. As CMS moves to review and consider successful models or innovations, we believe this is an area that warrants future exploration.

The models listed below are highlighted in NASEM's report, *"Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021)"* and/or in the April 2022 *JAGS* article, "*Complexities of care: Common components of models of care in geriatrics.*" For many of these models, we only list the name of the program or our comments are brief. While these models show great promise, most are limited in scope and not universally available.

Geriatric Models of Care

Acute Care for Elders (ACE) unit

AGS CoCare®: HELP, the Hospital Elder Life Program

AGS CoCare®: Ortho

Collaborative Care Model (CoCM)

Eden Alternative

Geriatric Resources for Assessment and Care of Elders (GRACE)
Home-Based Primary Care Model

Hospital at Home

Independence at Home (IAH)

Patient-Centered Medical Home (PCMH) – A geriatric PCMH is one of the strongest models for primary health care for older adults. For example, the PCMH at Sanford Health Care in North Dakota consists of geriatricians, gerontology ANPs, geriatric pharmacist, social worker, mental health tech, and a physical therapist. It is structured as primary care with embedded specialty care programs such as an interdisciplinary fall prevention clinic, geriatric consultation clinic, and memory clinic.

Programs for All-inclusive Care for the Elderly ("PACE") is a managed care program that was developed to enable individuals to live independently in the community. However, current policy has kept these programs siloed and has made adoption challenging. Barriers include the considerable time and monetary investment required of prospective PACE organizations and active support needed of state Medicaid agencies which can be difficult in times of severe budget and resource constraints.[1]

Innovative Workforce Models

Geriatric Interprofessional Team Transformation – Primary Care (GITT-PC)[2] focuses on a workforce culture change to empower primary care teams to achieve best practice in geriatrics in primary care. This program is focused on how patients can help transform the work of all team members in primary care including medical assistants, nurses, advanced practice clinicians, physicians, office managers, and support staff. Traditional content including effective communication, roles on teams, conflict resolution, and care planning is delivered in the context of team implementation of Medicare reimbursable primary care services such as Annual Wellness Visits, Chronic Care Management, and Advance Care Planning.

Project ECHO (Extension for Community Healthcare Outcomes)[3] is a program that has successfully established links between primary care providers in rural communities and expert specialists in academic health centers to help manage patients with chronic conditions through virtual clinics.

Innovations in Telemedicine

Telehealth support has shown to improve care for patients in SNF and assisted living facilities by decreasing emergency department utilization and hospitalization. Home health monitoring systems have shown similar improvements and better compliance and patient satisfaction. Telehealth can also be used to train and educate primary care providers and other specialists with the geriatrics competencies needed to adequately treat beneficiaries with multiple chronic conditions.

Community Support

High quality care for older adults can be supported through regular screening of barriers to care. In collaboration with community health workers or home health visits, individuals can be screened for common barriers (food insecurity and transportation) and create referral processes to community-based programs. Community Care Teams (CCTs) are locally based, multidisciplinary groups of care providers that have been implemented and scaled in some states, addressing medical issues *and* social drivers of health.

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[1] Bloom S, Sulick S, Hansen JC. Picking Up the PACE: The Affordable Care Act Can Grow and Expand a Proven Model of Care. *Generations*. 2011;35(1):53–55. https://www.jstor.org/stable/26555762

[2] S J Bartels, E Flaherty, N Tumosa, THE NEW GERIATRIC INTERPROFESSIONAL TEAM TRANSFORMATION IN PRIMARY CARE: AN IMPLEMENTATION SCIENCE APPROACH, *Innovation in Aging*, Volume 2, Issue suppl_1, November 2018, Page 30, https://doi.org/10.1093/geroni/igy023.111

[3] Project ECHO. Content last reviewed September 2020. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/patient-safety/resources/project-echo/index.html

Barriers to implementing successful models or innovations:

- Lack of training for interdisciplinary team-based care. Training is generally done in silos. We also need to create a culture of equity and train in settings outside the hospital.
- Structural racism and poverty are an obvious barrier to care due to workforce issues. SNF/NF and home care could be required to pay reasonable wage and have minimum staffing requirements.
- Encouraging future healthcare professionals to consider a career in primary care, including geriatrics, is a challenge because of financials disincentives. It is likely that a larger National Health Service Corps scholarship program would bring greater equity and lead to more primary care. Federal loan repayment for underrepresented specialties like family medicine, internal medicine, geriatrics, and primary care APRNs should be considered.
- Information sharing across disparate parts of the health system. A basic example: goals of care and advance care planning requires time to assess yet the results are not necessarily always available to treating providers and community-based staff.
- Lack of standardization of data elements to assess health equity; lack of self-reported race/ethnicity data to analyze interventions for disparities.
- Lack of inclusion of adequate numbers of older adults in published literature of many randomized controlled trials, making it difficult to assess whether than any intervention that works in the under 65 population has material benefit in an older, multi-comorbid population.
- Quality outcomes are still disease-based for many primary care models with insufficient stock of measures that account for whole-person care, quality of life, and individual patient preferences.
- Low levels of engagement in digital health solutions, low "digital literacy" for older adult populations in an era where more interventions are being scaled (sometimes exclusively) using video/smartphones that require broadband access and familiarity with basic tech tools.
- Patchwork funding leading to chaos and programs designed around funding rather than patients. Innovative programs like SNPs and PACE are successful because they break down those walls.

Successful strategies to engage communities:

Creation of Family Councils
The involvement of patients and their families in primary care can help to capture additional and valuable information providing a more holistic perspective and in turn bolstering the care and service provided to patients. One approach to facilitate involvement is to develop family councils (similar to NF) that can offer insights and input to help provide primary care and services informed by what matters to the patient and their families, enhancing patients' experience, and improve services and conditions. Implementing family councils may help to improve person-centered care as well as patient satisfaction.

Outreach to Traditionally Underserved
We recommend outreach to communities traditionally excluded from care to understand their true needs. Effective outreach may look like training networks for trusted community health leaders supporting outreach and employing individuals who may not otherwise work in the healthcare setting.

Proposed HHS actions:

Meaningful Geriatrics Expertise Input
Given geriatrics health professionals experience is in caring for older people with medical complexity or advanced illness, leading interprofessional collaboration, implementing knowledge of long-term care across settings and sites, and leading advance care planning, it is crucial to ensure the leadership across CMS programs includes geriatrics expertise, similar to formulary committees for Medicare Part D. This unique skillset is essential to ensure high-quality, effective, efficient, and coordinated care for older adults and all Americans as we age.

Encourage Age-Friendly Health Systems

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, the "4Ms," to all older adults in a system. The 4Ms are: What **M**atters, **M**edication, **M**obility, and **M**entation. The age-friendly movement also includes a specific focus on safe mobility as a key element and this topic encompasses falls and falls prevention. When implemented together, the 4Ms represent a broad shift by health systems to focus on the needs of older adults. Of interest, the Geriatrics Workforce Enhancement Program Coordinating Council released a compendium of cases studies around implementing age-friendly health systems in primary care.

Improve Geriatrics Education and Training for Healthcare Professionals Across All Disciplines

Funding for Graduate Medical Education (GME) does not require that hospitals and other sites provide training for caring for frail older adults with multiple illnesses. MedPAC stated that Medicare has never used these payments to affect medical education or the composition of the workforce[4] and institutions using Medicare dollars to support GME should be providing training to enable health professionals to develop competency in the care of older adults.[5] We encourage increased funding and statutory changes to create geriatrics curricula requirements for all appropriate trainees and produce health professionals prepared to care for complex patients.

Medicare Considerations

- Incentivize Medicare Advantage to enhance support for primary care potentially using 5-Star Measures that are primary-care specific rather than disease-specific.
- Discourage minimum spend requirement to allow flexibility of spending for learning collaboratives and transforming the health system.
- Develop new, more applicable high-quality primary care-specific measures for multimorbid chronically ill and with social challenges, aligning primary care measures with its definition and high-value functions to support the implementation of high-quality primary care, advance meaningful quality assessment and performance standards, and ensure accountability for primary care identification and implementation of a parsimonious set of measures that are fit for purpose.[6]

Improve Information and Technology System and Invest in Machine Learning

Given that primary care providers may spend more than half of a workday completing electronic tasks both during and after clinic hours,[7] it is critical that electronic health systems and its data are reliable as well as easily accessible and shareable by clinicians, other specialists, community-based organizations, patients, and caregivers, while also considering public health in the design.

Plan Towards Equity

In order to realize a just health care system, the health care workforce must both reflect and be better prepared to care for the populations that it serves. The lack of representation of people of color and/or from racially minoritized groups across the health professions must be addressed. How we train and support the next generation of health professionals must also change so that we are truly supporting trainees from diverse backgrounds to achieve success in their chosen careers.

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[4] Medicare Payment Advisory Commission. 2009. Report to Congress: Improving Incentives in the Medicare Program. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/reports/Jun09_EntireReport.pdf.

[5] Medicare Payment Advisory Commission. 2010. Report to Congress: Aligning Incentives in Medicare. Washington, DC: MedPAC. https://www.aacom.org/docs/default-source/grad-medical-education/jun10_entirereport.pdf?sfvrsn=2.

[6] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. doi:10.17226/25983 (p. 263)

[7] Bhakta K, Lee KC, Luke T, Bouw J. Impact of a Pharmacist-run Refill and Prior Authorization Program on Physician Workload. *J Am Pharm Assoc.* 2021;62(3):1-7. doi:10.1016/j.japh.2021.12.002