THE VALUE OF INTEGRATED PRIMARY CARE FOR OLDER ADULTS: CONSIDERATIONS FOR HEALTH CENTERS (WEBINAR SERIES)

SESSION 1: Improving Health Outcomes Through Integrated Care in Later Life

March 3, 2026

REMINDERS

- All participants are muted on entry to limit background noise
- Use the Q&A or chat box to ask a question during the session
- This webinar is being recorded and materials will be emailed to participants
- We would love to hear your feedback – please fill out our brief evaluation at the end of this session!

About Us

CapitalLink

Founded in 1995 | Nonprofit

- HRSA National Cooperative Partner
- Supporting health centers & nonprofits with capital, operational, and strategic planning
- National leader in facility, financial, and operational strategies

OUR VISION

We believe in a just future in which every individual is treated with dignity and respect and has access to quality healthcare, regardless of their ability to pay.

Partners in Health Care Impact Through Data, Strategy, and Capital

WWW.CAPLINK.ORG

ABOUT NCECE

Who We Are: Established in 2017, the National Center for Equitable Care for Elders (NCECE) is a training and technical assistance Center that provides innovative models of care, inter-professional training and educational resources to health care professionals providing care to older adults.

Our Mission is to build strong, innovative and competent health care models by partnering with health centers & primary care associations to provide quality care for older adults.

Stay Connected With NCECE:

- **Twitter:** twitter.com/NationalECE
- **Bluesky:** bsky.app/profile/nationalece.bsky.social
- **Facebook:** facebook.com/NationalECE
- **LinkedIn:** linkedin.com/company/ncece
- **Website:** ece.hsdm.harvard.edu
- **eLearning Library:** ncece.dialogedu.com/elearning-library
- **Email:** ece@hsdm.harvard.edu

SMALL GROUP TRAINING

Improving Community-Based Geriatric Care Community of Practice

Dates: April 7, April 21, May 5, May 19 from 2-3PM ET

Apply Today!

Andrea Wershof Schwartz, MD MPH, AGSF
Harvard Medical School

Arielle Mather, MPH
National Center for Equitable Care for Elders

Learn more & apply today!

SERIES LEARNING OBJECTIVES

- Describe the core components of high-quality integrated care for patients as they age
- Examine current care delivery to identify gaps and opportunities for implementation of age-friendly principles to drive practice change
- Identifying best practices for the development and implementation of Programs of All-Inclusive Care for the Elderly (PACE) in a health center setting

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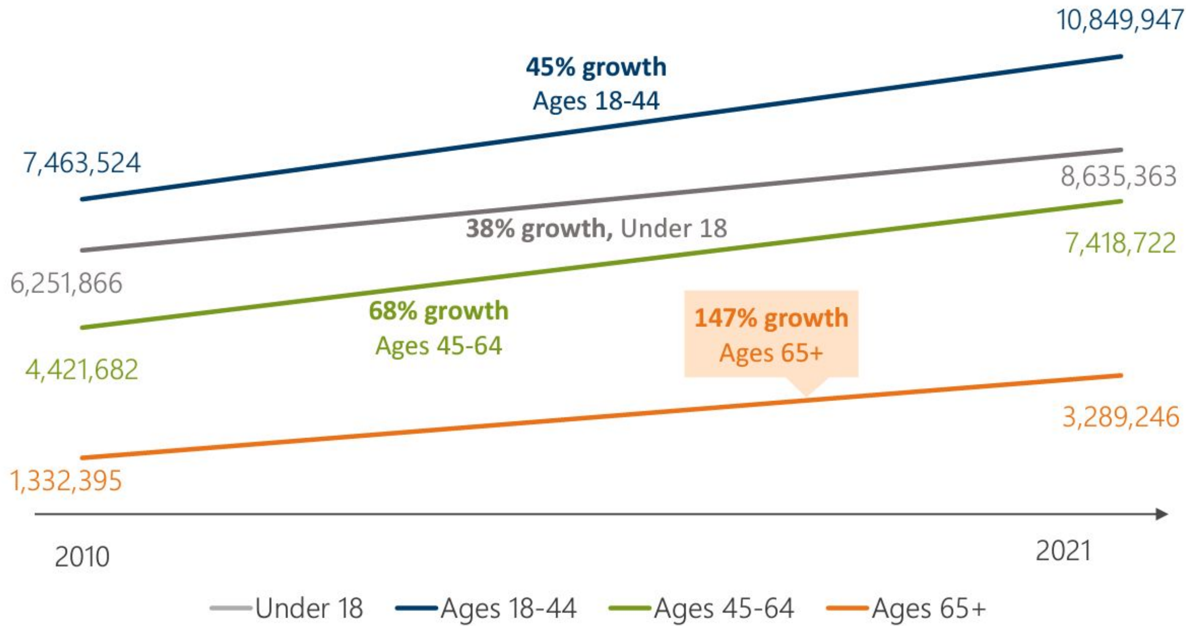

Community Health Center Chartbook (NACHC, 2023)

Older adults (65+) are the FASTEST growing patient group served by health centers

INACCURATE BELIEFS ABOUT LATER LIFE

- Misconception that certain conditions are inevitable as we age:
  - Pain/discomfort
  - Functional decline
  - Social isolation
  - Depression
  - Dementia
- Assumption that you can be "too old" to change health behaviors
- Portrayal of older adults in media: very fit or very frail

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AGING IN COMMUNITY

Most older adults wish to stay in the homes and communities **of their choice** as they age, instead of relocating to an institutional care setting.

Familiar environments support cognitive function, help maintain social connection, and are usually more cost-effective.

Aging in Place: Resources to Living at Home For as Long As Possible (NCOA)

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COMPLEXITY OF AGING

Medical
(chronic conditions, polypharmacy, oral health, cognitive changes)

Functional
(mobility, activities of daily living, frailty)

Non-Clinical
(housing stability, transportation, caregiving)

Behavioral
(depression, anxiety, isolation, grief, substance use)

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WHAT IS INTEGRATED CARE?

"Services managed and delivered in a way that ensures people receive a continuum of care across health and social care… Service delivery is integrated across sectors, settings and sites across the life course."

World Health Organization (WHO)

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[Integrated care for older people (ICOPE)]

National Center for Equitable Care for Elders

WHAT DOES INTEGRATED CARE INCLUDE?

- Health promotion
- Prevention
- Diagnosis
- Treatment
- Rehabilitation
- Palliative care
- Community-based services

ICOPE

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Integrated care for older people (ICOPE)

National Center for Equitable Care for Elders

BENEFITS OF INTEGRATED CARE FOR OLDER ADULTS

- → Reduced duplication of services
- → Improved service coordination
- → Reduced hospitalizations and ER visits
- → Improved functional capacity
- → Improved health outcomes
- → Improved quality of life

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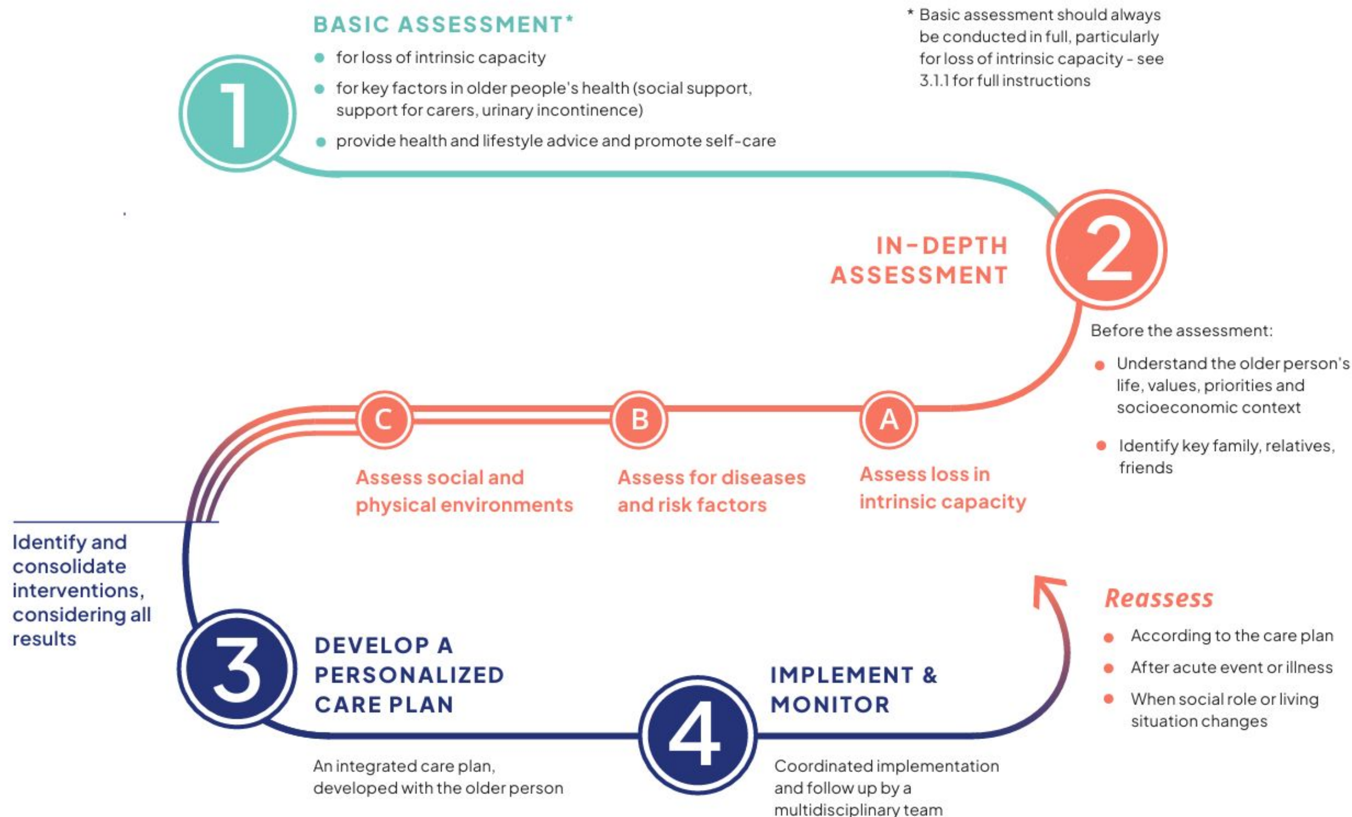
Integrated care for older people (ICOPE)



What is "Age-Friendly" Healthcare?

- Follows an essential set of evidence-based practices
- Cause no harm
- Aligns with *What Matters* to the older adult and their family caregivers
- Includes efforts that improve health outcomes for ALL ages

Age-Friendly Health Systems | Institute for Healthcare Improvement

Age-Friendly Health Centers recognize the connection among all of the *Geriatrics 5Ms*: Mind, Mobility, Medications, What Matters, and **Multi-complexity**

The Geriatrics 5M's: A New Way of Communicating What We Do

COMMUNITY-LEVEL INTERVENTIONS

- Community-based organizations (CBOs) can provide tailored support to older adults: nutrition, transportation, social connection
- Area agencies on aging (AAAs) coordinate and offer services that allow individuals to remain in their homes for as long as possible
- Partnerships between health centers and CBOs increase capacity to address health-related needs in later life

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

- Provides a comprehensive service package that allows frail, community-dwelling older adults to remain at home instead of long-term care
- PACE becomes the sole source of services for Medicare and Medicaid eligible enrollees
- Eligibility requirements:
  - Age 55 or older
  - Live in the service area of a PACE organization
  - Eligible for nursing home care
  - Able to live safely in the community at the time of enrollment

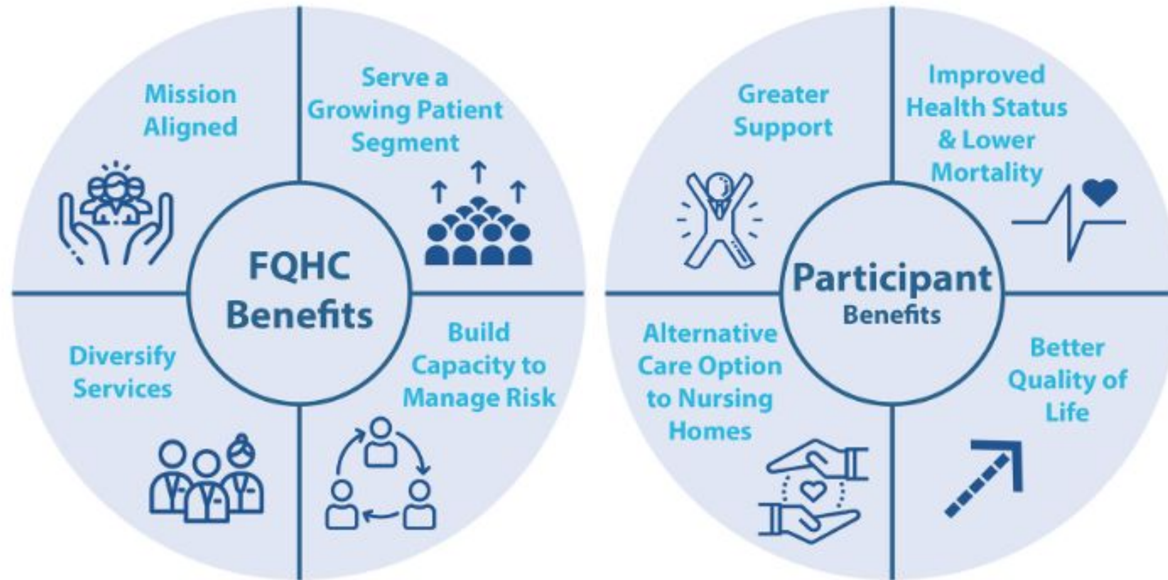
What is PACE?

Program of **A**ll-Inclusive **C**are for the **E**lderly is a community-based care option that allows older adults to safely remain living in the community. PACE provides comprehensive services, uniquely customized to each individual.

PACE Interdisciplinary Team

- Registered Nurse
- Recreational Therapist
- Dietitian
- Occupational Therapist
- PACE Center Manager
- Home Care Coordinator
- Personal Care Attendant
- Driver
- Primary Care Provider
- Master's of Social Work
- Physical Therapist

BENEFITS OF PACE



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DIFFERENT APPROACHES, SAME DESTINATION

- Enhancing care coordination within existing teams
- Adding new services like geriatric assessment or fall prevention programs
- Strengthening community partnerships to address health-related needs
- Exploring comprehensive models like Program of All-inclusive Care for the Elderly (PACE)

All paths lead to better health outcomes for older adults!

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UPCOMING SESSIONS

Session 2: Health Centers as Age-Friendly Health Systems

March 10, 2026

2:00-3:00PM Eastern

Session 3: Advancing Age-Friendly Care in Health Centers: Implementation, Success Stories, and Lessons from PACE

March 17, 2026

2:00-3:00PM Eastern

TODAY'S PANEL

Cheryl Modica PhD, MPH, BSN
Director, Quality Center, National Association of Community Health Centers

Michael Goldrich, MD
Physician, LifeLong Over 60 Health Center

Miriam Parker, DDS, MPA
Chief Dental Officer, LifeLong Medical Care

PANEL QUESTIONS

- How does your current work currently support integrated care for older adults?
- What is one misconception about caring for older adults in primary care settings that you wish more providers understood?
- When thinking about the complexity of older adults' needs (medical, social, functional), what are the greatest challenges you or others have faced?
  - What creative solutions have you seen work?
- For health centers interested in becoming more "age-friendly," what's one concrete first step you'd recommend them to take?

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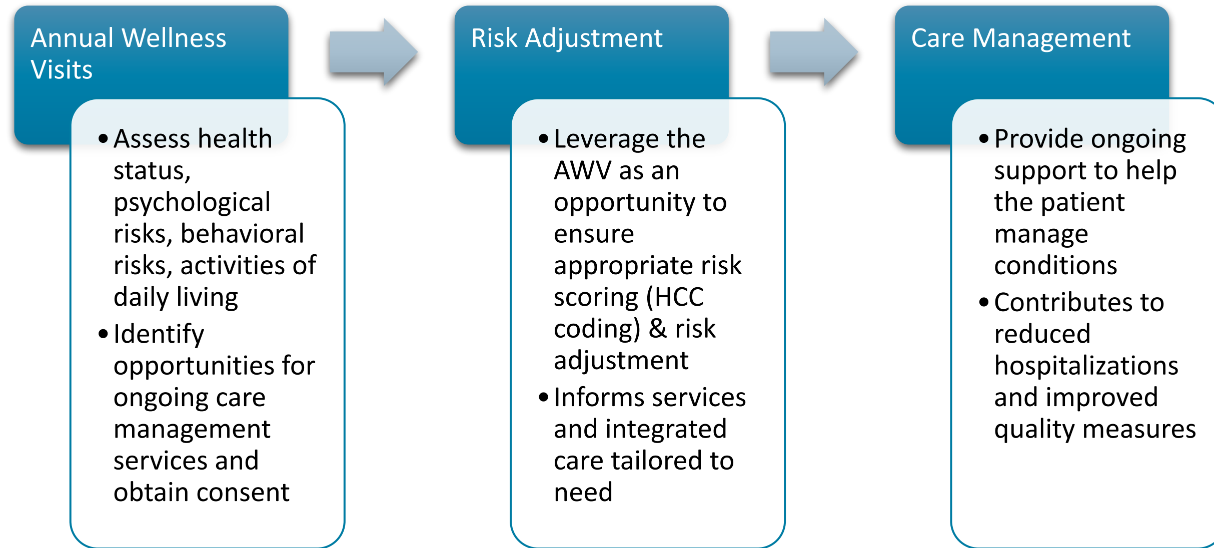
Supporting Integrated Care



Care models that support integrated care…

as well as revenue opportunities

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Summary of Medicare Care Management Services

Medicare Care Management Services:

- ✔ Chronic Care Management
- ✔ Complex Chronic Care Management
- ✔ Principal Care Management
- ✔ Transitional Care Management
- ✔ Chronic Pain Management
- ✔ Behavioral Health Integration
- ✔ Psychiatric Collaborative Care Model
- ✔ Community Health Integration
- ✔ Principal Illness Navigation
- ✔ Remote Physiologic Monitoring
- ✔ Remote Therapeutic Monitoring
- ✔ Advanced Primary Care Management

Summary Includes:

- ✔ Description
- ✔ Eligible patients
- ✔ Authorized billing providers
- ✔ Examples of auxiliary personnel
- ✔ Service elements
- ✔ Billing codes and rates

Summary of Medicare Care Management Services

See NACHC resource: ***Medicare Billing Lingo, Defined!*** for definitions of terms used throughout this document.

[Summary of Medicare Care Management Services]

Reimbursement Tip Sheets

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REIMBURSEMENT TIPS

Learner Roles:
Clinical & Quality
Operations & Administration
Patient & Community Support

Learner Level: 100 | 200 ✓ | 300

Payment

Medicare Wellness Visits: Chronic Care Management, Complex Chronic Care Management, Principal Care Management

Helpful Resources:

- Medicare Billing Lingo, Defined! for definitions of terms used throughout this document
- Summary of Medicare Care Management Services for an overview of Medicare care management services billable by FQHCs
- Sliding Coinsurance for Medicare Care Management Services for more information on sliding fee discounts for care management services

What You'll Learn from This Guide

- ✓ Explain the differences between CCM, CCCM, and PCM
- ✓ Outline the initiating visit, patient eligibility, and care team requirements for chronic care management services
- ✓ Apply correct coding, billing, documentation, and co-occurring service rules for FQHCs

Overview

Medicare's chronic care management services are personalized and supportive services provided to patients with chronic conditions to coordinate care and develop a care plan to achieve health goals.

- **Chronic Care Management (CCM)** services support individuals with multiple chronic conditions
- **Complex Chronic Care Management (CCCM)** services support individuals with multiple chronic conditions who require moderate or high medical decision making
- **Principal Care Management (PCM)** services support individuals with a single complex chronic condition

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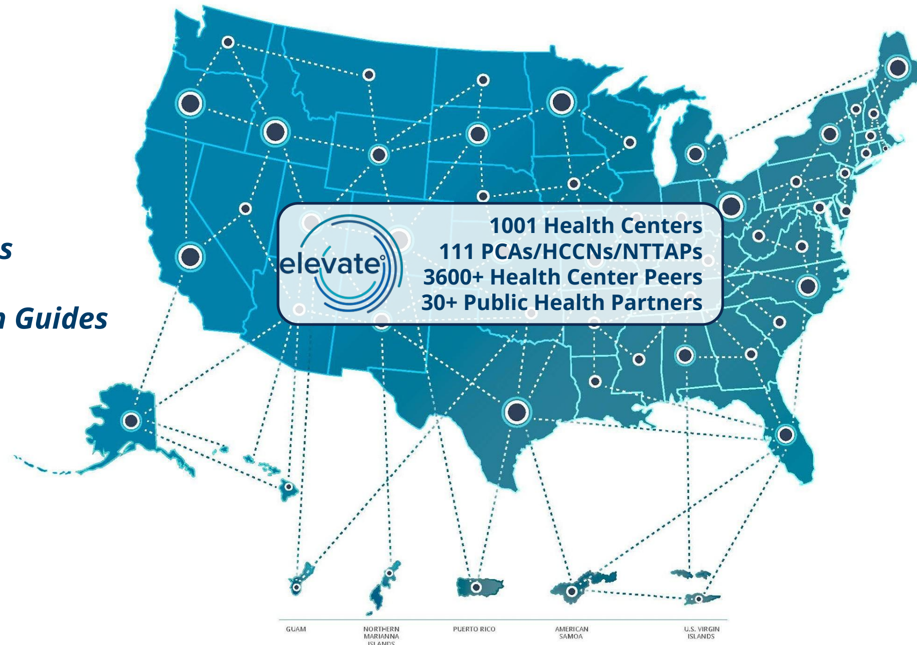
Reimbursement Tip Sheets

- Detailed guidance
- Simplified language
- Aligned with 2026 Medicare Physician Fee Schedule Final Rule

More than 15 Reimbursement Tips available!

Elevate 2026

- *Monthly Webinars*
- *Supplemental Sessions*
- *Evidence-Based Action Guides*
- *Action Briefs*
- *eLearning Modules*
- *Tools & Resources*



Share Elevate with others!

Elevate **is NACHC's national learning forum supporting health centers and partners to transform systems and enhance value**

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Three Pathways to Engage in 2026

Team/Organization

Teams and organizations engage in a guided transformation journey, beginning with the VTF Assessment, identifying priority areas, and applying Elevate tools and resources to strengthen systems and drive improvement.

Individual Pathway

An individual identifies their role, completes the VTF assessment to determine learner level, and engages in learning tailored to them.

Grab-and-Go

Individuals join Elevate and access resources on an as-needed basis. Resources are organized around the 15 change areas of the VTF.

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Visit NACHC's Elevate webpage for more information and to get started!

QUESTIONS?

THANK YOU!

Please take a moment to complete a brief evaluation that will help us improve future learning opportunities.

THANK YOU!

NEXT SESSIONS

March 10, 2026 2-3 PM ET (Session 2): **Health Centers as Age-Friendly Health Systems**

March 17, 2026 2-3 PM ET (Session 3): **Advancing Age-Friendly Care in Health Centers: Implementation, Success Stories, and Lessons from PACE**