

A CALL TO PARTNERSHIP

to Improve Care Coordination for Older Californians

PROMOTING TEAMS



Integrating teams of healthcare and supportive services is essential to providing quality care.

This is one of three documents describing Archstone Foundation's theory of change around integrating health and social services to improve the health and well-being of older Californians and their caregivers. We will pursue this goal through coordinated investments in our core strategies of promoting Teams, enhancing Training, and improving Technology.



Our Vision for Better Care

Archstone Foundation's mission is to improve the health and well-being of older people and their caregivers throughout California. Our vision is for all older Californians to have access to high-quality coordinated care that effectively integrates health and social services. We believe these integrated services should be culturally competent, client-centered, comprehensive, collaborative, coordinated, connected, and compassionate. We envision that care for older adults places them and their families at the center of a care team, to ensure their care preferences and goals are met. Central to our mission, vision, and core work is a commitment to justice, equity, diversity, and inclusion and a belief that addressing the intersecting issues of ageism, racism, sexism, and ableism is the only way to achieve high quality, integrated care for all people.

Understanding Our View of Teams

Our Teams, Training, and Technology approach recognizes that each area relies on the others to provide the preferred care of a person. The best care teams are well-trained, while technology is essential to both improving communications among team members and reducing barriers to training.

Defining Team Care

Team care is when a group of care providers in medical and social settings, ideally including an interdisciplinary group of coordinated providers, works across silos of care and involves the individual as well as family and friend caregivers.

Importance of Team Care

No health or social service professional has all the essential skills to meet the needs of older adults and their caregivers. For this reason, high-quality primary care that is integrated, accessible, and equitable – and provided by interprofessional teams – is essential to addressing an individual's health and wellness across different settings. Teams that are trained well, with the person and family at their center, lead to more equitable outcomes, improved patient and provider satisfaction, and reduced health care costs. Since primary care is the only type of health care in which increased supply is associated with improved population health and more equitable outcomes, strengthening the quality of integrated primary care teams is imperative.¹



Team Care in Practice

A useful example is the **UCLA Alzheimer's and Dementia Care Program**. It provides comprehensive support for patients with diagnoses of dementia or Alzheimer's disease, offering treatment plans that support both patients and caregivers. These involve teams of nurse practitioners and geriatric specialists, and the use of community-based resources for coordinated care. And unlike typical care – which is often uncoordinated, siloed, and managed only by oneself or a single caregiver – a dementia care specialist is assigned to support and coordinate the comprehensive care needed for persons living with dementia and their families. A personalized plan is developed with the primary care provider, ongoing patient monitoring is provided to ensure that ongoing and emerging needs are met, and training and support are provided to caregivers.

Another example is **the partnered collaborative care model**, which improves the reach and effectiveness of late-life depression care through the systematic involvement of community-based organizations, families, and primary care clinics that work with older adults. Typical care for persons experiencing depression is fragmented and uncoordinated. But this approach models the ability to access specialty care at the primary care level, combined with social supports in the community that supplement or help deliver necessary care. Such coordination takes extra attention, skill, and resources, but partnered collaborative care illustrates how teams can exist across entities and achieve quality outcomes for older people.

Caregivers as Part of the Team

While individuals provide the bulk of their own health care, family caregivers are essential to providing care when it comes to older persons with more complex needs. They are key players in both health care and social services settings – as are physicians, nurses, social workers, and direct care workers – but are not often formally recognized as part of care teams. Nor are they well-integrated with the care delivery systems of health professionals. Family caregivers interact with a range of providers and navigate a variety of systems, attending visits with physicians and facilitating hospital discharge processes, and they are expected to provide support to older adults with cognitive or physical impairments. But too many communication restrictions, lack of training, and other barriers exclude them from fully engaging in the care and services needed to optimize the health outcomes of their older family members.

Coordinated Team Care for Communities of Color

Teams must place older adults and their family at the center to ensure that their care preferences and goals are met. Communities of color and other marginalized groups experience worse health outcomes, which should not be the case in a just society that is appropriately prepared to meet the needs of all its members. The disparities and trauma these groups have experienced with healthcare systems are one reason why they are more likely to delay seeking care until health concerns become more serious problems. The Foundation is committed to ensuring that models of care teams meet the needs of historically marginalized and under-resourced communities, especially in connecting health care systems with social services. This is particularly important in California, the most culturally diverse – and the second-most racially and ethnically diverse – of the 50 states.

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Interweaving Justice, Equity, Diversity, and Inclusion Principles

Archstone Foundation is committed to integrating principles of justice, diversity, equity, and inclusion (JEDI) into its grantmaking strategies. Research, trends in the field, and voices from the communities we serve all tell us that funds need to reach further upstream, because an approach emphasizing direct services and treatment programs is simply not enough. What is needed instead is a more comprehensive grantmaking strategy that balances services with investments in structures, policies, and practices that result in more just, equitable, and sustainable outcomes.

Applying a JEDI lens to our work with care teams is an area of opportunity to work upstream through organizational practice change. Creating efficiencies and incorporating more equitable practices in team care allows our partners to adequately acknowledge and confront the drivers perpetuating racial disparities in our fragmented health systems.

One of the five main objectives is to pay for primary care teams to care for people, not doctors to deliver services. Another is to train primary care workers where people live and work.

- NASEM report

Opportunities in the Field

The Department of Health Care Services, the state's 58 counties, and Medi-Cal managed care plans are all working to meet the objectives of [CalAIM](#), California's five-year plan to improve quality of life and health outcomes, which is centered on a population-based approach, prevention, and whole-person care. As a result, changes in Medi-Cal (Medicaid) payment policy have the potential to support a broader array of social and supportive services as part of care plans, thereby creating an opportunity to advance effective team care. Many community-based organizations are in the early stages of learning how to work with managed care plans, and they need technical assistance and capacity-building support to successfully participate in the CalAIM initiative to deliver coordinated care.

A recent National Academies of Sciences, Engineering, and Medicine report, "[Implementing High-Quality Primary Care](#)," set these five implementation objectives to make high-quality primary care available to all in the United States:

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves patients, families, and the interprofessional care teams.
5. Ensure that high-quality primary care is implemented.

Funding Principles and Opportunities

Archstone Foundation will support projects that can advance models of care teams, demonstrate improved outcomes for older adults and their families with a focus on historically marginalized and under-served communities, and are structured to achieve more cost-effective and higher-quality care. Programs we now fund include the AC Care Alliance's Advanced Illness Care Program, a community-based program that provides lay health navigators from faith-based organizations as part of care teams for the seriously ill in a community setting. We are also supporting the Alzheimer's Association's effort to help teams at federally qualified health centers integrate cognitive assessment into older adults' primary care visits. And we are helping San Bernardino's El Sol Neighborhood Educational Center build capacity to develop strategic relationships with healthcare entities and bill for the services of its community health worker (promotores de salud) program.



Given our general principles, future Teams grants may include proposals to:

- *Adapt tested models to respond to the needs of diverse older adults and communities underserved by traditional care systems.*
- *Facilitate and establish connections between social services and healthcare systems.*
- *Promote community-based and clinical best practices that are comprehensive and utilize collaborative team care innovations.*
- *Provide additional resources to incorporate prior learnings and disseminate effective and affordable person-centered team care models.*
- *Increase organizational capacity for community-based organizations to partner with health care entities to bill for services provided.*

By joining with a wide range of thought partners and grantees and turning these plans into programs and initiatives, we will improve care coordination, reduce health disparities, and make a measurable difference to the health and well-being of older Californians and their caregivers. We look forward to partnering with community-based nonprofits, local and state entities, health systems, and others to bring Archstone Foundation's vision of integrated care to fruition.

¹ 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. <https://doi.org/10.17226/25983>



We Want to Hear from You!

If you are advancing models of care teams, demonstrating improved outcomes for older adults and their families, and achieving more cost-effective care, please [visit our website](#) to learn how you can partner with us.