Primary Care Modernization
Older Adults with Complex Needs
Design Group Meeting

November 2018
Agenda

Introductions 5 minutes

Discuss Questions Raised in Previous Session 70 minutes
- Role of Subspecialists
- Implementing the Capabilities

Sense of the Group 10 minutes

Next Steps 5 minutes

Adjourn
Questions for Discussion

Questions raised in the last session for further discussion:

• What is the role of subspecialists (e.g. pulmonologists, cardiologists, etc.) in providing primary care for older adults with complex needs?
  • What happens if someone is not attributed to a primary care provider?

• How will these capabilities be implemented in practice? How do we know providers will follow these best practices?
Revised Concept Map for Primary Care for Older Adults with Complex Needs

**Health Neighborhood**

- **Specialty Care**
  - Subspecialists (e.g. cardiologist, pulmonologist, etc.)
  - Acute care settings

- **Community & State Services for High Risk Older Adults**
  - Home care/aides
  - Hospice providers
  - Assisted Living Facilities
  - Connecticut Community Care
  - Caregiver support programs

- **Community Supports for all Older Adults**
  - Meals
  - Transportation
  - Housing
  - Handyman (Hand rails, etc.)
  - Community centers

**Advanced Network/FQHC**

- **Subset of Primary Care Practices Specialize in Geriatrics**
  - Home-based Primary Care
  - Dementia Care
  - Palliative Care
  - Advance Care Planning
  - Hospital, SNF, nursing home rounding

  Specialized expertise supported by Project Echo guided practice, practice experience, expertise and technical assistance for Advance Care Planning

- **All Primary Care Practices in AN/FQHC**
  - Diverse care teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)
  - eConsults between PCPs and subspecialists
  - Phone, text, email encounters
  - Telemedicine visits
  - Remote patient monitoring for CHF, post-acute care

Primary care teams link to services, coordinate care provided by specialists and in other settings

Referrals for High Risk Older Adults
Sally is 75 and lives at home alone. She has diabetes and her family is worried she may be showing signs of dementia. She sometimes forgets conversations she just had and recently forgot how to get to the grocery store. She also has trouble figuring out which medications to take when. She was recently hospitalized from chest pain and shortness of breath, and is being treated for heart failure.

Her PCP has eConsults with specialists about her care plan for diabetes and heart failure.

At her visit, the PCP assesses her for dementia, and talks to her and her son about her conditions.

A nurse care manager, gets her medical records from the hospital, her cardiologist and her endocrinologist.

The nurse care manager helps develop a care plan, schedules a home visit with a pharmacist, and refers her and her son to dementia resources in the community.

The pharmacist and care manager visit Sally at home and help organize her medications and set up a reminder system. They also give her information about OTC medications that interact with her medications.

The care coordinator follows up with Sally’s son about finding dementia resources and schedules a follow up the next month to check on her diabetes and HF.
Next Steps

• Incorporate today’s feedback and circulate to design group
• Task Force reviews and makes recommendation to Payment Reform Council (PRC)
Appendix
Task Force Considerations for Including Subspecialists as PCPs in PCM

The Task Force recommended that subspecialists are not eligible for participation in PCM after considering the following:

• Patients will always have the freedom to choose to have their primary care through a subspecialist. The subspecialist is paid Fee For Service for primary care services for patients attributed to them.

• Subspecialists have a limited number of patients for which they provide primary care, which will make it difficult to transform their practice for this small subset.

• Research suggests subspecialists are more likely to refer to other subspecialists for management of other comorbid conditions (diabetes, hypertension) and less likely to perform evidence-based, preventive screenings.¹

• Providing primary care via subspecialists is likely to increase costs as subspecialists are likely to have higher negotiated rates for E&M visits.

Common Capabilities from Successful Primary Care Models for Complex Older Adults

Primary care practices using intensive team-based care models to target high risk seniors show evidence of reduced hospital admissions, length of stay, and readmissions and improved patient experience. Common capabilities include:

- Multidisciplinary care teams
- Longer visits and smaller patient panels
- Same-day or next day appointments
- Addresses social determinants of health
- Care coordination in hospital and care transitions
- Behavioral health integration
- Customized electronic health record systems that focus on clinical issues rather than billing

Source: Modern Healthcare:
Case Studies

• **Commonwealth Care Alliance**: Senior Care Options integrated, team-based approach including home visits and care coordination for people who are dually eligible for Medicare/Medicaid and are nursing home eligible. CCA reports:
  - 4 out of 5 stars for 2019 CMS Services Star Ratings
  - 27% reduction in acute admissions per 1,000 from 2011-2017
  - 5.7% reduction in 30-day readmission rate from 2012 - 2017

• **CareMore**: Targets high-risk, chronically ill patients using hospital extensivist model to provide team-based care coordination and disease management during hospitalization and care transitions. CareMore reports:
  - Lower 30-day hospital readmissions rate than for overall Medicare population (13.6% v. 19.6%)
  - Members’ per capita health spending was 15% less than the regional average
  - Hospital length-of-stay was shorter: 3.2 days compared to 5.6 day average in Medicare fee for-service

• **ChenMed**: High intensive team-based primary care for seniors with multiple conditions. A recent evaluation conducted by ChenMed and the University of Miami found:
  - Increased primary care physician visits and use of preventive medication
  - Reduced hospital admissions than standard Medicare Advantage primary care patients
  - Reduced per member per month costs than standard Medicare Advantage primary care patients ($87 v. $121)