

## PCM Complex Older Adults Design Group 2

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**Participants:** Stephanie Burnham, Laura Roix, Maria Dwyer, Patricia Richardson, Alyssa Harrington, Ellen Bloom, Stephanie Marino, John Freedman, Joan Conley

### What We Heard in Session 1- Consumer Needs

- Communication between primary care physicians and subspecialists is lacking, often because of lack of shared data between the two, especially with different Electronic Health Record systems.
- Lack of care coordination and understanding of complex, rare illnesses in primary care. Managed care should be designed so PCP can manage the care across specialists, not be experts in everything.
- Older adults need to be their own advocates, but they need communication between PCPs and specialists to understand the full picture.
- Depression and alcoholism are rising concerns in the older population due to isolation and boredom and there typically aren't integrated services.
- PCPs have challenges completing DME orders and sometimes patients don't get the supplies they need or the right amount because of it
- PCPs don't have enough time with patients because of how the system is designed. Support moving to new payment model that will address this.

One consumer noted that for the DME orders, this is not a PCP issue. PCPs do what they're supposed to, but it is the suppliers who are restricting them. FHC asked if it is the supplier or the payer that's putting these restrictions in place. According to one consumer, some patients on oxygen have to go and pick up their own oxygen tanks. Suppliers think they're losing money, so they're restricting what they provide patients. Suppliers just aren't delivering anymore or are charging for delivery outside of insurance. Another consumer agreed that the PCPs are very good at providing the orders that are needed, as well as the subspecialists. For the company that is providing the oxygen, it becomes an issue of what patients can get.

One consumer explained that the problem is often due to Medicare competitive bidding processes and multiple suppliers. Medicare reimbursements and DME supplies should be reimbursed, but not all supplies are offered by every supplier. Another consumer noted that you can't find a supplier in the state of Connecticut that will supply liquid oxygen to patients. FHC summarized that it appears this problem lies outside of the primary care system.

A consumer explained that the Medicare number is available to patients to make complaints about billing, and that it's important for patients to advocate for themselves. They noted that it's important for the primary care team to understand that the patient is having these challenges. FHC acknowledged that this speaks more to ensuring there is clear and reliable communication amongst the parties and diversified care teams in which a care team member such as a patient navigator can help patients contact Medicaid and work on solutions to these issues.

### What we Heard in Session 1- Approach

Capabilities for all Primary Care Providers

- Expanded care teams including care coordinators, home care providers, pharmacists, behavioral health clinicians
- Telemedicine visits and phone capabilities for those who don't feel comfortable using a computer
- Coordination and communication between PCPs and subspecialists
- Reducing documentation burden on clinicians by having other care team members such as physical therapists help with orders
- Health Information Exchange or shared Electronic Medical Record system between PCPs and specialists

- Involving caregivers in discussions and decision-making (while keeping care patient-centered), allowing for choice of providers
- Geriatricians help educate PCPs in geriatrics care, more focus on this in medical training to address workforce gaps

Subset of primary care practices

- Conduct home based primary care visits
- Clinician makes rounds at nursing home facilities and inpatient settings and communicates back to PC team
- Specialization in dementia care based on interest and training

#### **Capability Requirements to Address Consumer Needs**

- Increased communication between PCPs and subspecialists (e.g. cardiologists, endocrinologists, etc.) in the network through eConsults
- Expanded care teams to address behavioral health, medication management, care coordination needs, help PCPs with DME and medical supply orders
- Care coordination to coordinate between providers, and connect patients and families to community and state services e.g. caregiver support programs
- Access to telemedicine visits
- Patients will continue to have choice of provider. Payment model attribution methodologies will support this.
- Subset of practices in the network specialize in geriatrics care.

One consumer explained that they keep a copy of their medical record and test results to bring to PCP appointments. They do the work of making sure all providers are informed. Being able to download records and take them with you on a thumb drive is very important because not all networks are able to connect with one another. FHC explained that for eConsults, PCPs and subspecialist don't have to be in the same network but will share patient data across the same platform. This will be a part of the capability that the networks build for practices. Connecticut's HIE will also be important for sharing health information across providers with different electronic health record platforms.

One consumer noted that many of these capabilities are already in place and are the best standard of care, but many providers aren't doing them. For example, PCPs should be communicating regularly with specialists, but it's just not happening. It's not happening even with new reimbursement models, so what is being suggested that would improve the incentive to have better best practices? What is being suggested to improve this?

FHC agreed that a well-functioning practice should be doing these things. To participate in PCM, there are going to be more requirements and the Payment Reform Council is currently working on accountability measures and quality measures practices. Providers will need to meet these in order to get the enhanced upfront payments. This incentivizes providers to provide the best standard of care—there is not this incentive in a fee for service system.

A consumer inquired if it's possible to ask PCPs if what prevents them from being able to improve coordination with specialists is not the financial system but instead is due to administrative burden. FHC explained that it is often difficult for PCPs to do this because of not having sufficient time and support. When someone is newly diagnosed, the practice does step-up, but less urgent cases fall through the cracks. That is why this model aims to enhance the funding for this to build-in some financial incentives for PCPs to fulfill this function (and to do it well). A consumer agreed that they believe PCPs simply do not have the time, and a payment model that allows time for these functions is ideal. FHC also noted that expanded care teams would allow other team members to conduct

care coordination. The group discussed the need to include the patient experience in accountability measures. The Payment Reform Council is considering this.

It was discussed how specialists who see patients the most frequently often act as the primary care provider for this patient. There was a question whether this effort designated who a patient's PCP is and whether subspecialists are considered PCPs. FHC explained that the Practice Transformation Task Force's provisional recommendation is that a PCP would include, for example, a geriatrician, but would not include subspecialists. This does not mean these subspecialists could not continue seeing their patients, they just wouldn't get the bundled/supplemental payment. A consumer asked whether in this situation the patient would be assigned another PCP, even though the subspecialist serves as the PCP. It was explained that the Payment Reform Council is talking through this attribution methodology now, and that FHC can circle back to this group with what this methodology will look like.

A consumer expressed concerns that this was missing the mark for most older adults with complex needs because they often see their subspecialist as their PCP. These patients truly feel this specialist is their source for all their primary care needs and the hub of these patients' medical care is centered around individual health issues. A payer explained that it comes down to how the physician notes their specialty and whether they identify as a PCP, which most specialists do not even if they provide primary care to a handful of patients. It was noted subspecialists only provide primary care to a small percentage of patients, they should not be reimbursed as a primary care physician.

Another consumer explained they have a PCP, they don't see that PCP and their specialist team provides all of their care, including all medication prescribing. It would be ideal to have a PCP who could do this, but sometime a PCP is simply not needed or appropriate. One consumer offered a counterpoint and explained how they're fortunate in their condition and their PCP understands their condition and needs and provides their care.

The group discussed that primary care practices specializing in geriatrics care would not replace subspecialists, but would rather enhance coordination with them and provide enhanced services and preventive care for these patients.

A consumer expressed concerns with the model as presented and asked how it would actually be implemented. It was not clear how practices having these capabilities would mean the patient would benefit or what the outcomes would be. It was explained that the Task Force will be putting together an overall framework of all capabilities and what ACOs should be able to provide in primary care. Once there is agreement on an overall framework, there will be another year's worth of work to develop implementation details. There will be opportunities for all the stakeholders in this process to comment on the draft framework. A consumer noted that while they understood that this was a framework, further discussion may be helpful. The group discussed how the Payment Reform Council will recommend what we would expect practices to demonstrate in terms of assessing performance in a patient-centered way and how to use Electronic Health Records to document patient encounters. A consumer expressed the need to improve the experience of beneficiaries as the focus.