PRIMARY CARE MODERNIZATION

Care for Older Adults with Complex Needs

CORE CAPABILITY

Enhanced primary care from a practice specially designed to improve outcomes for patients age 75+ with multiple chronic conditions, functional challenges, trouble traveling to in-office visits, and more likely to have potentially avoidable emergency department (ED) visits and require nursing home placement.

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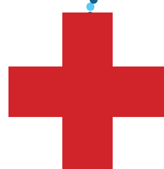
HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have a primary care team that understands how to care for older patients with complex health needs
- Get care at home to help you follow your care plan or when you have difficulty leaving your home
- Use phone, text, email, and telemedicine to get more convenient care, coaching, medication adjustment and support
- Avoid unnecessary trips to the emergency department or hospital
- Get help from a care coordinator or community health worker to connect with community-based resources or medical providers
- Get help when you go home after staying in a hospital, nursing facility or rehabilitation center



PRIMARY CARE TEAMS CAN...

- Include an array of staff with special expertise and training in caring for older adults with complex health needs
- Tune your practice workflows and accommodations to better address the problems commonly encountered by older adults such as hearing and cognitive issues, including dementia
- Offer home visits, telemedicine, and remote patient monitoring to support patient engagement, improve self-management, optimize the living environment to improve chronic illness outcomes and reduce risk (e.g., falls prevention)
- Improve Advanced Care Planning and access to palliative care
- Improve care coordination and patient navigation across systems and care settings

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Dan is an 85-year-old patient with high blood pressure and diabetes. Recently, his wife has noticed he gets confused sometimes. He visits his primary care provider, who specializes in geriatrics care, after an unexpected hospital stay.

During the visit, his doctor reviews his medical record and notices three emergency department visits in the past six months. One time he fell. Another time his blood sugar got too high. The third visit was for a urinary tract infection.

During a risk assessment, Dan and his wife say he forgets about appointments and his medications. Also, they don't drive anymore, so office visits require planning. Dan agrees to a home-based primary care plan written by his physician and a nurse home care provider.

A nurse visits Dan's home weekly to support him in taking his medication properly. A community health worker shows Dan how to have a video visit with his doctor and arranges transportation for office appointments. She connects Dan's wife to a caregivers' support group.

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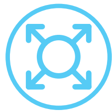
HOW



Care Team and Network Requirements

A subset of primary care providers specialize in advanced primary care for older adults with complex conditions:

- Hire and train an expanded, diversified care team with expertise in geriatric care
- Provide home-based primary care services
- Coordinate access to subspecialists and community-based supports, link to community-based services
- Develop practice workflows and accommodations to better address the problems commonly encountered by older adults such as functional impairments, including durable medical equipment needs, hearing and cognitive issues, problems associated with multiple medications and age-related medication considerations, and common mental health issues such as depression and loneliness
- Provide access via phone, text and email and telemedicine when appropriate
- Prioritize practice locations that are accessible for the communities they serve
- Establish remote patient monitoring for patients with Congestive Heart Failure for post-acute care and eConsults with subspecialists as needed
- Provide specialized care for patients with dementia
- Receive advanced training in and offer palliative care and end of life services to minimize discomfort, provide referrals to and coordination with hospice care
- Establish clinical links to institutional care settings, rounding by primary care providers to transition patients back to home setting and coordinated aftercare
- Subset of providers supported by Project Echo guided practice and technical assistance for Advanced Care Planning

Health Information Technology Requirements

- Electronic Health Record (EHR) that is accessible by all care team members and on mobile devices outside the office
- Health Information Exchange (HIE) to communicate with all members of the patient's care team
- Scheduling system accessible to all members of the patient's care team.
- Remote patient monitoring technology as needed for patients

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience regarding timely care, communication, coordination, specialists, provider support and overall satisfaction with provider
- More convenient patient access to care

★ Quality

- Earlier diagnosis and treatment for some conditions
- Improved preventive care (e.g. influenza immunization)
- Improved chronic illness outcomes
- Reduced avoidable ED visits and hospitalizations for ambulatory care sensitive conditions
- Improved care plan adherence
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Reduced avoidable visits, tests and procedures
- Reduced urgent care, ED, nursing facility and hospital utilization
- Lower out of pocket costs for services in primary care and by non-billable care team members

Access

- Easier access to high quality support from primary care team outside of traditional office visits
- Reduced wait time for diagnosis and treatment for some health problems
- Easier access to expertise of a specialist

IMPROVING HEALTH EQUITY

Early life stressors increase risk of dementia and other health conditions, which puts patients with greater social needs at higher risk of nursing home placement and uncoordinated care. To reduce these disparities, primary care will change in the following ways:

✓ **Text, phone, email, telemedicine care avoids barriers** to in-office visits like transportation.

✓ **Reduced out-of-pocket expenses,** which can be a barrier to care for fixed income patients.

✓ **Primary care provided at home or in the community** helps older adults with complex needs receive needed care and stay in their homes.

✓ **Practices specialized in geriatrics care** improve coordination between providers and community services.

LEARN MORE!
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SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities

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ADVANCED NETWORK/FQHC TEAM-BASED CARE

Patient & Family

ALL PRIMARY CARE PRACTICES IN AN/FQHC

Diverse Care Teams (CHWs, pharmacists, care coordinators, BH clinicians, etc.)

Telemedicine visits

eConsults between PCPs and specialists

Remote patient monitoring for CHF, post-acute care

Phone/text/e-mail encounters

SUBSET OF PRIMARY CARE PRACTICES

Specialize in Geriatrics for Patients with Complex Needs

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

Home-based Primary Care

Dementia Care

Palliative Care

Advance Care Planning (Project Echo)

Acute care setting rounding & care transitions support

HEALTH NEIGHBORHOOD

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

Specialty Care
Subspecialists (e.g. cardiologist, pulmonoglist, etc.), acute care settings

Community & State Services for High Risk Older Adults
Home care/aides, hospice providers, assisted living facilities, Connecticut Community Care support programs

Community Supports for all Older Adults
Meals, transportation, housing, handyman (hand rails, etc.), community centers