

Primary Care Modernization Complex Older Adults Design Group 1

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Participants: Laura Roix, Joan Conley, Patrick Coll, Mark Schaefer, Maria Dwyer, Stephanie Burnham, Margaret Gerundo, Stephanie Marino, Andy Selinger John Freedman, Brian Boates, Alyssa Harrington, Ellen Bloom

Purpose of Design Group

- What are the core elements of this capability?
- What should be provided by all primary care practices to better support older adults with complex needs?
- What specialized care should be provided by the network or a subset of practices or providers within the network?

Consumer Needs

- What are we missing?
 - FHC went over the provided Consumer Needs materials.
- Consumer: When it comes to complex issues, PCPs need to be more educational on what those issues are. Common issues are fine, but when it comes to more rare illnesses, there needs to be more education.
 - My PCP is not a gate keeper for me. My PCP does not understand my very complex, yet rare, condition.
 - Education is important for PCPs and staff.
- Consumer: I went looking for a PCP who would work with me and my illness
 - One of things I find lacking is the communication between PCPs and specialty doctors. They do not have a clear picture of what is going on.
 - I really need to see better communication between PCPs and subspecialists.
- FHC: Do consumer have experiences with a care coordinator to help you?
 - Consumer: I do not.
 - Consumer: There is a difference between PCPs and specialists.
 - As far as communication and understanding the community physicians, none of them have patient-sharing data, unless you're in the same group. The computer systems do not share with each other; therefore, they can't look at their computer screen and say the "primary care doctor did this" and they can't call those doctors to learn more.
 - I need to be empowered to know everything about my condition and care. I don't think that many older adults are there yet because they have so much faith in what their doctors are saying. We must advocate for ourselves. The doctors don't have the resources or the money to be able to say, "I'm going to call these people to make sure I'm coordinating that care." They don't have time for that, so you can't blame them.
 - But, when you talk about that subspecialist field, I do have a coordinator that coordinates everything through them. I have a transplant team, and they're my gatekeeper. This really shouldn't be the case. The gatekeeper should be my primary care doctor.

- Depression and alcoholism are also rising in older adults. The reason it increases is because of boredom, and there aren't any behavioral health services integrated for the older persons.
 - Consumer: I agree. I'm fortunate that my primary care physician works with me and works with my disease. One of the things that I find lacking is trying to have primary care physicians and specialty physicians communicate with one another to have a clearer picture. Not all physicians are aware of all diseases that people have as they get older. My conditions require a myriad understanding of the staff to know why I might need a larger tank to go out. I can't use a tiny one because I need 8 liters to be able to walk to my mailbox.
 - The big thing is communication. Not only with the primary care providers, but with the subspecialists as well to coordinate the services.
 - FHC: Not every doctor knows everything. It is crucial to be your own self-advocates. If PCPs are not at the center of your care, should they be at all? Or, should it be the relevant specialist for the significant chronic illness? What way should this system work?
 - Consumer: I feel most confident with the specialists for the conditions I have.
 - My PCP does my blood work and treats me when I have a cold or an infection.
 - No one can be an expert in everything. Therefore, the communication is so important.
 - When I first got sick, I was in a different area of the country. Those doctors communicated with each other directly. I always found that reassuring. Here, I think doctors look at the results of the tests that have been done, but doctors don't communicate to understand what the underlying causes are.
 - The older patient believes what their doctor says and do not challenge authority figures. I have someone come with me when I go to my doctor, so they can challenge what the doctor says sometimes.
 - FHC: Why was the communication better there?
 - Consumer: They weren't sure what was wrong with me. I was a mystery. That is why they were talking, I believe. I was fascinated with the fact that they would call up and talk to another doctor.
 - FHC: The barriers to communication are so high, an emergency will get people to talk, but for routine complex care, it's just sometimes too hard.
- Provider: One of the greatest barriers in an integrated group is that PCPs don't go to the hospital and do not communicate with hospital doctors. The only relationship they have is on paper. Is there a way to reestablish the communication with specialty colleagues?
- Consumer: I don't believe that managed care was designed to have the primary care doctor as the gatekeeper. I believe that managed care was designed to manage all these things together. We do have this kind of sharing in Connecticut. I went to one of the best cardiology hospitals, and they immediately got on the phone with Brigham Women's transplant team until they shipped me by helicopter. So, we have that here, it's just unfortunate with managed care. We have doctors that look at their watch and say, "okay, their 15 minutes is up," and it's not their fault. It's the fault of the system.

- Provider: We need to incorporate some linkages between nursing home care and doctors.
 - Consumer: I agree.
- State: There are several elements here that are touch stones for a model that would address these issues. In the payment model, we are trying to get the PCP more time with the patient and reallocate roles to different members of the patient care team.
- FHC: We will go deeper into communication between specialists and primary care providers.

Older Adults with Complex Needs

- FHC: went over the provided meeting materials for this definition and capability requirements
- FHC: reviewed the draft concept map for older adults with complex needs
- Consumer: I do think that home visits are important. With the elderly, they are always going to say that they feel fine, but they need a caregiver who can see that that's true.
- State representative: Patient-centered care is key, but we need to make sure the care givers are involved and a part of the process. What involvement of the primary care giver is needed to define that? We need to make sure there is a choice in providers. How would this work?
- Consumer: I agree with that. We don't have a choice when it comes to some things, we just go with it (i.e. people who are on oxygen). We are overwhelmed. We need to emphasize this with the caregiver. This would save everyone money if we can have a caregiver keep patients out of the nursing home and in the community.
- FHC: Would diverse care team member be helpful?
 - Consumer: Well, I had people help fill out that paperwork, but the thing is, they don't know when a provider gives you ten E tanks and says, "look, this is going to have to last you a month." Well, you have no other choice but to stay home because those ten tanks aren't going to last you if you were to lead a normal life outside of the home.
 - FHC:
 - How would providers be better educated for PRC? What resources are needed?
 - How can diverse care members conduct rounders in a facility?
 - Consumer: The doctors no longer do rounds at the hospital. We have hospitalists and I don't know that they really communicate over what your needs are when you go home from the hospital. I don't know how much communication there is between doctors inside and outside the hospital.
 - FHC: For older adults with complex needs, how would rounders play out?
 - Provider: I would say that what you would need is a clinical representative or an APRN that makes rounds and can communicate back to the primary care group. You need a clinical linkage back to the primary care group. When they go home, you need a clinical individual to interface with the sickest ones who were in the hospital. Must try to connect back to primary care office. So, that's what needs to happen to restore better communication for those who need it the most.
 - Consumer: Why isn't this just a normal team?
 - Provider: We now have care coordinators to help with this.
 - Consumer: That's pro health to pro health.
- Provider: I agree in principle with what you're trying to achieve. Volume-based reimbursements for primary care has never served us well. It's challenging to take care of patients in 15-20 min.

When primary care is done well, and patients have access to it, it decreases utilization in certain parts of the healthcare system. Allowing a primary care team to not be so volume-driven, and to allow other member of the care team to coordinate is good. There aren't enough providers to care for people over the age of 99, so our job is education, systems and models of care for older patients. What you do in the end makes primary care more attractive, but it's going to take time once you establish that model for medical students to see this as more attractive. So, you might have a gap in terms of workforce issues.

- FHC: One of the things we are talking about is staging implementation.
- Provider: One of the issues we are having in geriatrics is the amount of bureaucracy and documentation, so anything that can be done to decrease the bureaucratic responsibilities that practices have would be helpful. We are spending an incredible amount of our work week dealing with these issues, and it takes us away from time we could be spending with patients.
 - If a patient needs a walker or device, and are also seeing a physical therapist, that person is better than I am in prescribing that equipment. However, I'm the one to prescribe this equipment. Other members of the care team are better qualified for this kind of sign off, but it doesn't necessarily have to be the physician that does it.
- FHC: Went over key questions for design group.
 - State representative: We are often dealing with conflict between doctors. As a caregiver, you are discounting someone, so perhaps someone with a specialty to avoid putting the two against each other. Care coordinators would be helpful, especially in end-of-life care.
 - FHC: You're saying it would be helpful to have some kind of subset?
 - State: It comes down to communication, and yes that would be helpful.
 - Consumer: It's difficult to get physicians, nurse practitioners, and others to specialize in a field.
 - Provider: We should look at the fellowship opportunities (there are at least a dozen). I don't think you can mandate that each advanced practice network has fellowship-trained family physicians, but many family doctors like to hone in on one particular area (it doesn't take them away from primary care but allows them to have a directed interest).
 - This is important for the aging population.
 - Provider: You can create that expertise within Advanced Networks.
 - Provider: I'd support that approach. Someone who is older would deal with their primary care physician other than someone in geriatrics, then you can have someone do primary care, with a special interest in geriatrics.
 - FHC: So, it wouldn't be a mandate that every AN have PCs with specialties in areas, but there is support for training and filling in the gaps in terms of what's available.
 - Is there anything else missing from the model? What about telemedicine?
 - Provider: That must be a part of the network, but unsure it can be a part of every site within a network.
 - Consumer: Because my primary care transplant is out of state, I talk to the physician (or my daughter does or the nurse). Someone does, and so I think that that's important.

- Telemedicine: I think we need that under primary care because if you don't feel well, you don't want to leave your house.
- I think its hard to change some of us old folks also, and some people don't want to go onto the computer. I think there's a lot of education that needs to go on with the consumer as well as the doctor's office.

Next Steps:

- FHC:
 - We appreciate the personal stories.
 - Will take what we heard here and revise this model. We will circulate this to the PTF, and then we'll circle back to you and let you know what their recommendations were.
 - We have one more session on Oct 19th in the morning.