



CONNECTICUT
Office of Health Strategy

Primary Care Modernization Older Adults with Complex Needs Design Group Meeting

October 2018

Agenda

Introductions	5 minutes
Recap from Last Session	10 minutes
Discuss Revisions to Older Adults Capability	60 minutes
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

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.

Anything to add?

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 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 still 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

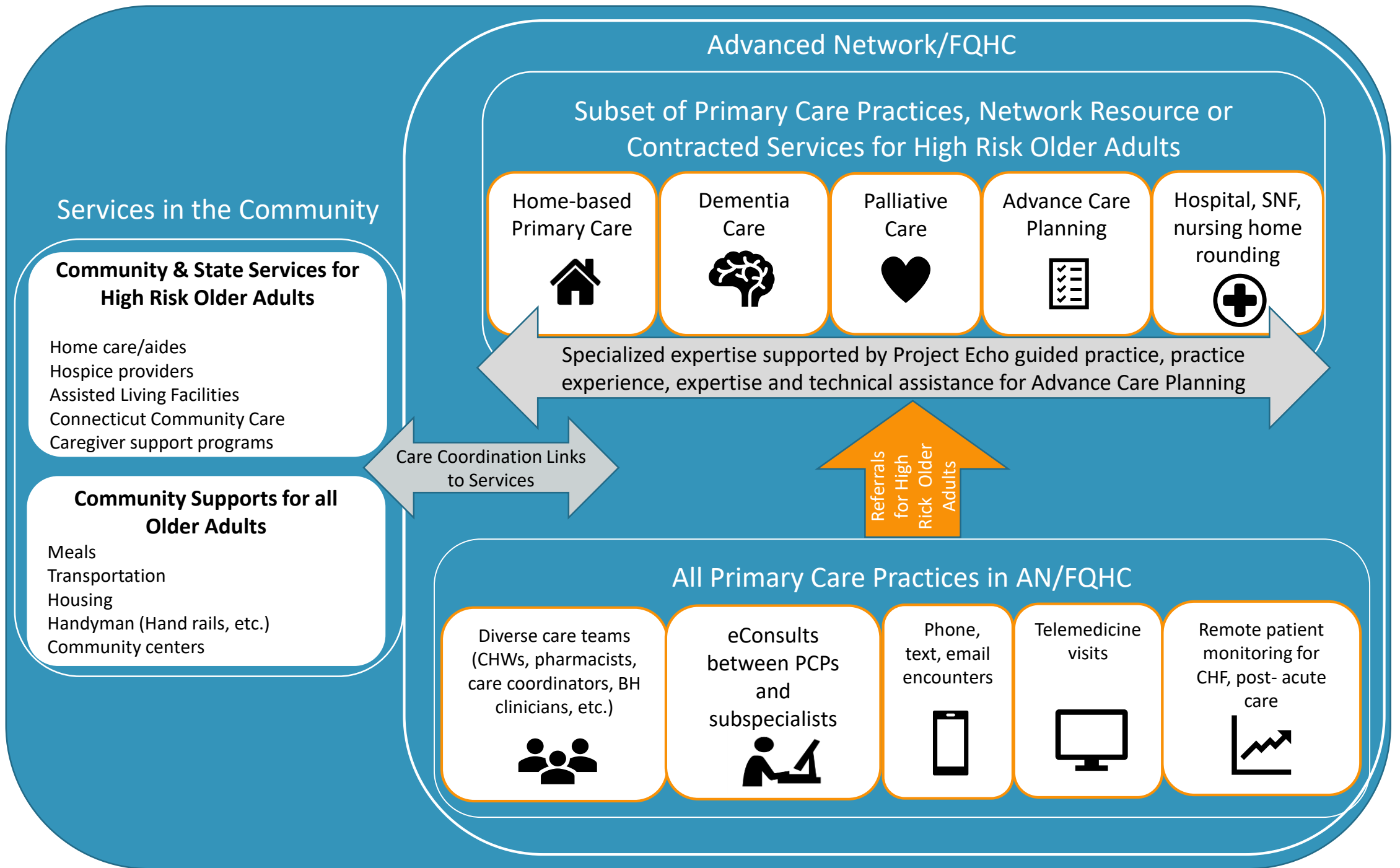
- Increased communication between PCPs and subspecialists (e.g. cardiologists, endocrinologists, etc.) in the network through eConsults
- Expanded care teams to address behavioral health, medication management, care coordination needs, help PCPs with DME and medical supply orders
- Care coordination 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 pediatrics practices in the network specialize in geriatrics care

Additional Capability Requirements

Subset of Primary Care Practices specialized in geriatrics care provide (in addition to home based primary care services):

- **Hospital, Skilled Nursing Facility and Nursing Home Rounding:** Primary care clinician (physician, PA, APRN) makes hospital rounds for high risk older adults in network who have been admitted and communicates back to PC team
- **Advance Care Planning:** Practice has experience and expertise on advance care planning and complex care conversations with older adult patients and families facing complex care decisions and end of life choices
- **Palliative Care and End of Life Services:** Practice has experience and expertise in palliative care for elderly patients with underlying conditions that are irreversible or progressive
- **Specialized Care for Patients with Dementia:** Practice has experience and expertise in dementia care

Revised Concept Map



Key Questions for Design Group

- What elements of this diagram would you change?
- Should all networks have a subset of primary care practices that specialize in geriatrics care (dementia care, advance planning care, palliative care)?
- Is hospital/SNF/nursing home rounding by a subset of PCPs a feasible model?
- Should the State support technical assistance in Advance Care Planning for a subset of primary care teams?
- Should practices specializing in geriatrics have any other areas of expertise?

Next Steps

- Collect today's feedback and incorporate
- Circulate to design group for additional feedback
- Send to Task Force for review
- Task Force makes recommendation to Payment Reform Council (PRC)