DRAFT Primary Care Modernization Project Capability Summary
Care for Older Adults with Complex Needs

Meeting Notes from Design Group Meetings are attached at the end of this document. Please note the Design Group is in the process of reviewing this summary.

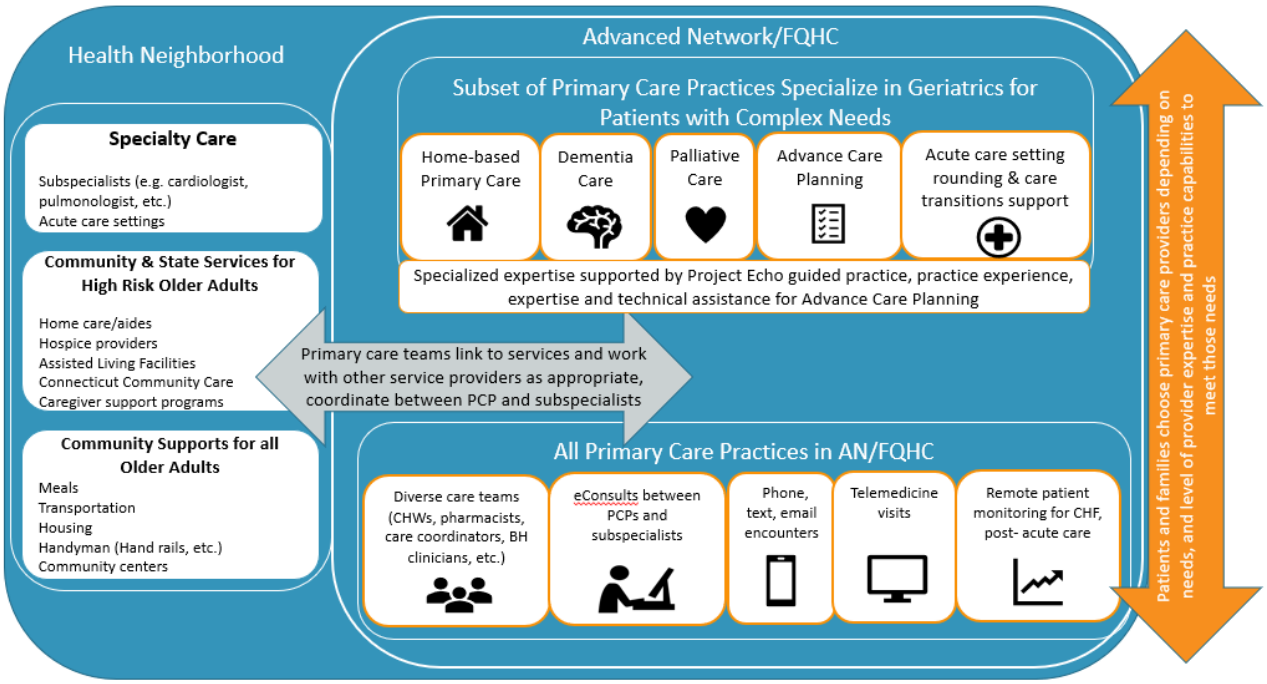
Definition of the Capability: Enhanced primary care for aging patients (over age 75) who are high risk through expanded capabilities for all practices and a subset of practices within the Advanced Network or FQHC that specialize in geriatrics for patients who are high risk. Patients who are high risk are those who may have multiple chronic conditions, frailty, functional challenges, report difficultly traveling to in-office visits and are more likely to have preventive emergency department (ED) visits, and/or may qualify for nursing home placement.

Goal of the Capability: Increase primary care practice and network capacities and resources to provide person-centered primary care for older adults with complex needs. The purpose of practices that specialize in geriatrics care for those with complex needs is to build centers of expertise within Advanced Networks and FQHCs to provide primary care services such as home-based preventive and chronic care and closing care gaps that meet the unique needs of this population.

Consumer Input, Questions, and Concerns for Implementation: Feedback from consumers on Design Group, AARP, CT Alliance for Retired Americans

- Primary caregivers (e.g. family members) need more support managing care needs.
- Expanded range of support services that go beyond traditional in office care, such as text, email, phone, telemedicine.
- Barriers to care include transportation and getting to medical appointments especially if frail or disabled
- Hearing and cognition issues may impair understanding of self-management instructions as well as non-native language comprehension.
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients
- Desire to keep existing physicians and better communication between physicians across systems and care settings
- Single point of contact in practice to connect with and coordinate care
- Need pharmacists, patient navigators, more community health workers to get connected to community programs and interpreters
- Challenges with suppliers fulfilling DME orders and insurers covering supplies and delivery, primary care team should be aware of challenges and support patients with this
- Caregiving support for patients after leaving hospital or nursing home to follow up with them.
- Home visits and care coordination are very important for people with complex needs.
- Insurance is a challenge in terms of understanding billing and finding providers accepting Medicaid patients

Concept Map for Primary Care for Older Adults with Complex Needs



Summary of Capability

Capability Requirements	All Practices within AN/FQHC	Subset of Practices within AN/FQHC
Expanded and diversified care team to address care coordination, navigation, medication, behavioral health and social determinants of health needs, such as care coordinators, Community Health Workers, pharmacists, behavioral health clinicians, nutritionists, and medical interpreters.[1]	●	
Subspecialist eConsult capabilities to provide clinical guidance to primary care providers on routine management of conditions through a shared data platform	●	●
Access to non-office based care when appropriate, including phone, text and email encounters and telemedicine visits	●	
Remote patient monitoring for patients with Congestive Heart Failure post-acute care	●	

[1] The Practice Transformation Task Force has made recommendations for core care team functions and members that may fulfill those functions. This is not an exclusive list and practices may form care teams most appropriate to meet the individual patient's needs.

Home-based primary care services, including in-office risk assessment, home visits to provide preventive and acute care, care coordination and patient navigation, assistance with transportation and other social determinants of health needs	●
Specialized care for patients with dementia, including initial assessment and diagnosis, develop treatment plans, refer to subspecialists as needed, care coordination, connection to resources	●
Expertise in Palliative Care and End of Life Services to minimize discomfort, referrals to and coordination with hospice care	●
Expertise in Advance Care Planning and making complex care and end of life decisions	●
Clinical links to institutional care settings, including hospitals and skilled nursing facilities, rounding by PCPs with support from the primary care team 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	●

Recommendations for Implementation

- Maintain patient/family choice of providers while providing resources and education about the benefits of primary care and specialized practices.
    - All patients and families have freedom of choice to choose their primary care practice and provider, whether within a network or independent practice.
    - Networks are required to have a subset of practices that specialize in geriatric care for patients with complex needs. Depending on their needs and preferences, patients and families may choose to see a primary care provider within one of these practices to benefit from their expertise and additional services specialized to geriatric care. It is the responsibility of the network to make patients aware of these resources and their benefits.
    - Patients may choose to continue to see a subspecialist as their primary care provider to maintain continuation of care and receive services in one place. Subspecialists are not eligible to participate in PCM and would be paid fee-for-service for patients attributed to them. Networks may provide education to patients about the importance of having a primary care physician, including:
        - Primary care physicians are specialized in providing whole-person team-based care, identifying gaps in care, coordinating care, addressing preventive care needs, and addressing social determinant risks.
        - Specialists are highly trained to operate independently in a narrow band of care, and provide intense episodes of care, such as hospitalizations. They typically provide consultation rather than ongoing, continuous, coordinated, comprehensive care.
        - Research suggests that subspecialists are less likely to meet patient's primary care needs, e.g., they 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.

  - Patients who are attributed to a practice that is participating in PCM should be informed by the network/practice of what the demonstration project is, what services are available to them, the payment model, and how this differs from non-participating practices.

- Avoid duplication in care coordination and other services that are provided through Medicaid waivers and other community support programs.
  - Medicaid waiver program participants have a care coordinator that is responsible for coordinating the long-term services and support (LTSS) plan, including coordination to support medical needs, such as getting to necessary medical appointments. When an individual's acute and chronic medical needs increase, there *may* be value in having medical services coordinated by the practice's nurse care manager in coordination with the LTSS care coordinator who would retain responsibility for coordinating waiver services. In all cases, the individual should decide whether the practice's nurse care manager is needed, in consultation with his or her circle of support, PCP and LTSS care coordinator. Advanced Networks should develop coordination protocols with Medicaid waiver programs that set mutually agreeable processes for determining who is responsible for supporting the coordination of an individual's acute and chronic medical needs. Protocols should specify how individual choice determines decisions about who leads the medical care management and how the LTSS care coordinator can participate in the primary care team process.[2]
  - Care coordination within the practices should also help identify older adults who would benefit from available state and community supports, improve awareness of such supports, and foster the practices ability to effectively refer and link to these supports.

- Consider providing a financial incentive for providers that are successful in avoiding nursing home placement for Medicare beneficiaries and for whom there are associated cost savings with respect to the use of skilled nursing facilities.

[2] This language is consistent with the CCIP protocol for avoiding duplication with the DSS CHNCT Intensive Care Management program and other cross sector initiatives.

Understanding the Need

The Problem: In 2012, the Centers for Medicare and Medicaid published a report showing 37 percent of Medicare fee for service beneficiaries had four or more chronic conditions. This group of older adults account for nearly three-quarters of Medicare spending (Centers for Medicare and Medicaid Services, 2012). Many of these patients see multiple specialists and have difficultly following treatment plans - which can lead to further complications (Hostetter, Klein, McCarthy, & Hayes, 2016). The primary care office - often the first point of contact for these patients - has traditionally played an important role in coordinating patient care. Providing care for multiple chronic conditions while helping patients navigate complex healthcare systems has proven difficult and these patients frequently report care that is poorly coordinated (Bodenheimer, 2007). Communication among providers is often limited and subpar care coordination has been shown to have serious impacts on health care spending, health outcomes, and overall care experience (Bodenheimer, 2007). With a continuously aging US population and a steady increase in the number of chronically ill patients, primary care physicians require additional support to maintain the basic care needs of their elderly, chronically ill patients.

Proven Strategy

Name: Enhanced Primary Care for Older Adults with Complex Needs

Definition: Enhanced primary care for aging patients (over age 75) who are high risk through expanded capabilities for all practices and a subset of practices within the Advanced Network or FQHC that specialize in geriatrics for patients who are high risk. Patients who are high risk are those who struggle to manage multiple chronic conditions, report difficultly traveling to in-office visits and are more likely to have preventive emergency department (ED) visits, and/or may qualify for nursing home placement.

Goal: Increase primary care practice and network capacities and resources to provide person-centered primary care for older adults with complex needs. The purpose of primary care practices that specialize in geriatrics care for those with complex needs is to build expertise within primary care to provide primary care services such as preventive care and closing care gaps that meet the unique needs of this population.

Capability Requirements

All Primary Care Practices have the following capabilities for older adults and those with complex needs:

- **Diverse Care Team**[3]: Care teams include a diverse set of roles and their membership can vary depending on the program, needs of the patient population, and services offered. Care team members are integrated within primary care and provide services during in-office, telemedicine, or home care visits. Care team members most applicable to the needs of older adults commonly include (Stratis Health and KHA Reach, 2014):
    - **Home Care Provider:** A nurse, nurse practitioner, or physician assistant who provides health care services in office or within the patient's home. The clinician supports overall adherence to care and manages the patient's conditions by providing preventive services and routine

[3] The Diverse Care Teams design group is defining care team member functions and roles for expanded care teams in primary care, as well as what cross training is needed for special populations like older adults with complex needs. Definitions will be aligned based on their recommendations.

care to promote improved health outcomes and chronic condition management to keep the patient living in the home setting. The home care provider communicates and coordinates care with other members of the care team.

- **Care Coordinator:** The Care Coordinator performs a care continuum process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a patient's health needs, using communication and available resources to promote quality, cost-effective outcomes.
- **Community Health Worker:** Connects patients to relevant community resources and aims to address social determinants of health needs and support the patient in adopting healthy behaviors and self-management techniques. These services may include health and wellness, legal assistance, health insurance assistance, meal delivery, home maintenance and others. They also support home care providers by ensuring patients are transported to in office visits and provide emotional support to patients.
- **Health Coach:** In collaboration with other members of an integrated primary care team, the health coach helps patients meet their preventive, chronic and acute care needs. Coaches engage patients and encourage them to take an active role in their health by providing them with the tools necessary to make healthy lifestyle choices. For older adults, health coaching would focus on supporting self-management of chronic conditions.
- **Nutritionist:** A nutritionist provides education, nutritional and health assessments, counselling and teaching, patient focused nutritional plans and behavior change support within the scope of practice. Nutritionist may provide support to older adults in adjusting their diet to adhere to new medication or better manage chronic illnesses.
- **Pharmacist:** Conducts comprehensive medication reviews that target specific conditions, conduct medication reconciliation, provide comprehensive medication management for patients with multiple chronic conditions, provide medication monitoring and care coordination across multiple prescribers and pharmacies, and tailored medication action plans. Pharmacist services may be provided in-office, through telephone interviews, home visits, or a combination of methods (Stratis Health and KHA Reach, 2014) (Reidt, Morgan, Larson, & Blade, 2013).
- **Interpreter**: Medical interpreters provide medical translation services to non-English speakers. They help patients communicate with medical staff, doctors, and nurses and have been identified by consumers as a need by older adult consumers.

- **eConsults between Primary Care Providers and Subspecialists:** Primary care providers have access to eConsults with subspecialists inside and outside of the network. eConsult is a telehealth system in which PCPs consult with specialists using asynchronous electronic communications before referring an individual to a specialist for a face to face visit. Subspecialists provide clinical guidance to primary care providers on routine management of conditions. With eConsults, PCPs and subspecialists have access to and share patient data across the same platform.

- **Access to Non-Visit Based Care through Phone/Text/Email:** Primary care offices provide expanded access to care team members through non-office- based communications, including secure phone, text, and email encounters and advice lines for minor medical issues and questions instead of requiring in-office visits.

- **Telemedicine Visits:** Telemedicine visits are between clinicians and patients through virtual real-time communications such as video conference. These interactions may involve remote patient

monitoring and other digital technologies (such as smart phones) to support provision of care. Telehealth visits are provided for the following types of interactions:
    - Urgent care or same day visits outside of a practice's normal business hours, or when an in-office visit is not available.
    - Routine care that can be provided outside of the office setting for identified individuals.
    - Behavioral health needs.
    - Remote or home patient monitoring for chronic conditions or after an acute care episode, with a virtual visit to connect with the patient to discuss an issue, provide medical guidance or education, or adjust the treatment plan.

- **Remote Patient Monitoring:** Patients with congestive health failure are provided remote monitoring devices for post- acute care which collects patient health and medical information and transmits it to the primary care office for assessment and recommendations. A member of the primary care team (typically a nurse) monitors the information and follows up with the patient via phone, home visit or in-office visit as needed.

A subset of primary care practices within the network have experience and expertise to provide all specialized services listed below for high-risk older adults with complex needs:

- **Project ECHO Guided Practice in Geriatrics:** Primary care providers complete Project Echo-Geriatrics guided practices. This consists of monthly sessions that connect clinicians to University of Washington (UW) geriatric specialists by videoconferencing. The staff includes fellowship-trained geriatricians, a geriatric pharmacist, a geriatric psychiatrist, and a clinical social worker. The sessions cover a wide range of issues relevant to older adults within the context of primary care (Bennett, et al., 2018). Project ECHO- Geriatrics ensures providers are prepared to recognize and address the complex nature of common elderly conditions, set priorities for care, manage care coordination, and follow up with patients after a hospital discharge (Boult, Counsel, Leipzig, & Berenson, 2010).

- **Home-Based Primary Care (HBPC):** Utilizes physician supervised care teams by providing health services in the home of identified high risk older adults (may be the patient's own home, a family home or community home). Key components of Geriatric HBPC models are (Rich, Lipson, Libersky, & Parchman, 2012)**:**
    - **Risk Assessment**: The in-office risk assessment is conducted by the patient's primary care physician. The assessment may include a review of the patient's medical history, current conditions, medications, social support, and care preferences. The provider may also screen for early signs of cognitive conditions such as Alzheimer's or dementia and assess the patient's activities of daily living (ADLs) and Instrumental activities of daily living (IADLs). Based on the assessment results, the physician determines if the patient would benefit from HBPC. If so, the physician may use the current appointment, or schedule a follow up, to introduce the home care provider. This allows trust to be built between the two parties. The patient's primary care provider and home care provider work together to create and implement a patient centered care plan that addresses all of the patient's health-related needs in the context of the patient's preferences. Goals are jointly agreed on and clearly explained to the patient during a follow up visit or during the initial home visit.
    - **Home Visits:** Patient centered health care services are delivered in the home by the home care provider. Home visits may be performed by the home care provider or other members

of the care team, such as the health coach, community health worker, or pharmacist to carry out their various roles. Services cover medical care for chronic conditions, disabilities, and prevention based on the patient's care plan. During the initial visit, the home care provider may conduct a scan of environmental factors contributing to illness or structural risks that increase the chance of accidents, such as falls (Agency for Healthcare Research and Quality (AHRQ), 2014). A home visit is also scheduled following an unexpected hospitalization. During this visit the provider assesses what caused the hospitalization and determines what can be done moving forward to prevent future hospitalizations.

- **Care Coordination and Patient Navigation:** Care coordination involves deliberately organizing patient care activities and sharing information among all members of the care team. The care coordinator meets routinely with the care team to review patient problems and develop solutions. This ensures patient needs are prioritized and communicated to the right care team members. The care coordinator also coordinates with specialist physicians, hospital staff, rehabilitation therapists, mental health professionals, and others who are outside the patients care team. The care coordinator also connects patients with other agencies that provide care to older adults. This may include, hospice providers, assisted living facilities, and others.

- **Hospital, Skilled Nursing Facility and Nursing Home Rounding:** A primary care clinician (physician, physician assistant or advanced practice registered nurse) makes hospital rounds and provides care for high risk older adults identified by the network who have been admitted. This clinician communicates back to the primary care team and works with the care coordinator to manage the patient's care following discharge and support transition back into the home. A Patient follow up visit is scheduled following discharge reducing the chance of readmission (Jackson, et al., 2015).

- **Advance Care Planning:** Primary care practices in the network specializing in care for older adults have experience and expertise in advance care planning. Primary care providers and care teams receive technical assistance on advance care planning and complex care conversations with older adult patients and families facing complex care decisions and end of life choices. Providers discuss and documented conversations with seriously ill older adult patients about end of life and advanced care goals.

- **Palliative Care and End of Life Services:** Primary care practices in the network specializing in care for older adults have experience and expertise in palliative care for elderly patients with underlying conditions that are irreversible or progressive (Commonwealth Care Alliance, 2018). Palliative care goals include:
  - Primary care providers and care teams provide services to minimize discomfort, manage symptoms and enhance the ability to be with loved ones at the end stages of life
  - Services provide relief from pain and other symptoms of chronic conditions such as fatigue, nausea, shortness of breath, and loss of appetite
  - Services are commonly provided at the patient's or a caregiver's home by the home care provider
  - Palliative services are always included when a patient is enrolled in hospice care but focus on keeping the patient in their home for as long as possible
  - Referrals to and coordination with hospice care as needed

- **Specialized Care for Patients with Dementia:** Primary care providers in the network specializing in care for older adults have experience and expertise in dementia care. For patients with dementia, the CT State Unit of Aging Alzheimer's Task Force recommends (CT General Assembly, 2013):
    - Provide initial assessment and diagnosis of dementia, develop patient treatment plans, and refer to subspecialists as needed
    - Provide care coordination services and connections to support services, including a care coordinator to counsel a newly affected family through the care process, assess individual and caregiver needs, and assist in navigating and accessing services.
    - Provide a checklist of information and referrals to the Alzheimer's Association, Area Agencies on Aging and other community resources

Intended Outcomes:

- Keep older adults with complex conditions in the home, avoiding nursing home placement
- Reduce avoidable Emergency Department visits
- Reduce hospitalizations, length of stay and readmissions
- Identify new and/or worsening conditions sooner
- Ease care transitions to the home following hospitalizations
- Increase coordination/access to a range of services for patients who report difficulty to outpatient medical offices
- Increased patient engagement
- Better understanding of the patient's home environment
- Increased patient and primary caregiver satisfaction

Consumer Input, Questions, and Concerns:

- Primary caregivers (e.g. family members) need more support managing care needs.
- Expanded range of support services that go beyond traditional in office care, such as text, email, phone, telemedicine.
- Barriers to care include transportation and getting to medical appointments especially if frail or disabled
- Hearing and cognition issues may impair understanding of self-management instructions as well as non-native language comprehension.
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients
- Desire to keep existing physicians and better communication between physicians across systems and care settings
- Single point of contact in practice to connect with and coordinate care
- Need pharmacists, patient navigators, more community health workers to get connected to community programs and interpreters
- Challenges with suppliers fulfilling DME orders and insurers covering supplies and delivery, primary care team should be aware of challenges and support patients with this
- Caregiving support for patients after leaving hospital or nursing home to follow up with them.
- Home visits and care coordination are very important for people with complex needs.
- Insurance is a challenge in terms of understanding billing and finding providers accepting Medicaid patients

Health Equity Lens:
- Transportation barriers make it difficult for older adults to access primary care in office-based settings.
- Older adults are more likely so suffer from multiple chronic conditions and are ill equipped to manage them.

Implementing the Strategy

Example Scenario: A 78 year old patient with hypertension and diabetes arrives at his primary care visit following an unexpected hospitalization. During the visit, the provider reviews his medical record and notes three recent emergency department visits in the last six months. This initiates a risk assessment. During the risk assessment the patient shares difficulty getting to appointments and following his diabetes medication schedule. It's agreed the patient will move forward with HBPC. The physician and a nurse home care provider draft a care plan centered around the patients' conditions, needs and limitations. It's determined the patients would benefit from the assistance of a home care nurse and a community health worker. A nurse visits the patient's home twice a week to monitor diabetes management, ensure overall medication adherence, and provide services relevant to the care plan. The nurse shares the patient in-office appointment schedule with the care team community health worker. Transportation is coordinated by the community health worker if necessary.

HIT Requirements:
- An electronic health record (EHR) that is accessible by mobile devises.
- A 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 need for patients.

Implementation Concerns:
- Frequency/distance of home visits decreases the number of patients care teams can manage.
- Specialist face to face visits still required for complex patients.
- Need to clearly define and document communication channels.
- Appropriate selection of high risk patients.
- Risk of overtreatment due to increased patient provider interaction time.

Impact

Aim	Summary of Evidence
Health promotion/prevention	Patients receiving nurse facilitated home-based care were more likely to receive a flu shot (74% vs 67%), have a follow-up primary care visit within 6 weeks of a hospital discharge (83% vs 54%), receive a medication list (58% vs 38%), and newly report having a health care representative or a living will (44% vs 17%) compared to the control group (Boult & Wieland, Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions, 2010). Increased continuity of care is associated with improvements in delivery of preventive care and

	reduced preventable admissions (Wallace, Salisbury, Guthrie, Lewis, & Fahey, 2015) (Nywelde, et al., 2013). Patients enrolled in Guided Care and insured by Kaiser Permanente had 47 percent reduction in admissions to skilled nursing facilities (Boult, et al., 2011).
Improved quality and outcomes	Evidence supporting care coordination and expanded care teams is mixed with studies showing varying degrees of health improvement. A systematic review of literature found that care coordination and planning lead to minor but statistically significant improvements in physical and psychological health status. Patients were found to have an increased capability for self-management of conditions compared to usual care. Effects are more pronounced when interventions are more comprehensive, intensive based, and integrated into routine care (Coulter, et al., 2015). An analysis of the GRACE model showed significant improvements in care coordination during transitions and in geriatric-specific care including fall evaluations and depression treatment (Counsell, Callahan, Buttar, Clark, & Frank, 2006). Compared to traditional care, interventions involving nurses who provide patient-centered geriatric condition management improved disease control (Katon, et al., 2010).
Patient experience	Following 18-month home-based intervention participants were more likely to give high-quality ratings to the Guided Care program compared to usual care (Boyd, et al., 2009) and patients consistently report improved access, communication, coordination, and decision making in coordinated models (Hudon, Chouinard, Diadiou, & Bouliame, 2015).
Provider satisfaction	Evidence supporting provider satisfaction regarding home-based coordinated care is strong. In two RCT studies, physicians reported greater satisfaction with the care patients received compared to the control group (Counsell S. , Callahan, Tu, Stump, & Arling, 2009) (Marsteller, et al., 2010) and primary care providers reported overall quality of care satisfaction with the Mass General Integrated Care Management Program (Kodner, 2015).
Lower Cost	In an RCT study of 951 high risk adults age sixty-five and older, patients enrolled in provider coordinated home based care had fewer visits to emergency departments and hospitalizations resulting in reduced hospital costs compared to the control group. The intervention saved $1,500 per patient by the second year (Counsell S. , Callahan, Tu, Stump, & Arling, 2009). An analysis of the Integrated Care Management Program – which coordinates care and creates personal care plans for adults with complex conditions- found that return for every dollar spent yielded $2.65 in savings for the first cohort and $3.35 for the second (Kodner, 2015).

Please complete the survey on this capability **here.

APPENDIX

Learning from Others

Case Study #1: The Commonwealth Care Alliance (CCA), a Massachusetts based not-for-profit, offers their Senior Care Options (SCO) health plan which supports HBPC for seniors struggling to maintain multiple chronic conditions. CCA has more than 28,000 members and offers SCO to patients over the age of 65 who are covered by MassHealth. Care plans include all services covered under MassHealth and other benefits determined necessary by the patients care team in conjuncture with CCA's preferred provider network.

SCO was created to offer patient- centered care to older individuals with serious illnesses that would ultimately end up receiving care in a nursing home. 65 percent of patients are nursing home certifiable yet are able to live at home with care support. SCO helps members live safely and independently at home through an integrated, team-based approach. Working with primary care providers, an interprofessional care team and specialists create care plans that address each member's medical, behavioral health and social support needs. Using this approach, the program has improved patient quality of life and reduced long- term costs associated with hospital admissions and emergency department utilization.

Results:

- 88 percent of SCO members who have been receiving services for at least nine years are still living at home
- 27 percent reduction in acute admissions
- 5.7 percent reduction in 30-day admission rates
- 4 percent reduction in overall outpatient costs
- 1.9 percent reduction is overall acute inpatient cost between 2015 and 2017

Case Study #2: CareMore is an integrated health plan and care delivery system specifically for Medicare and Medicaid patients. Currently, the organization serves more than 100,000 patients across 8 states. The company developed a care model that targets high-risk, chronically ill patients through focused care coordination, patient education, and proactive disease management.

The company achieves this through three program components:

- **CareMore Neighborhood Care Center**
    - CareMore operates a network of community-based clinics designed to supplement the care provided at a patient's primary care office. The goal is to provide an all-inclusive care experience, reduce travel time and duplication of services. All clinics provide a range of services primary care services as well as mental health services, diabetes management, wound management, and hypertension management. Recently, the program started offering transportation through ride-sharing application Lyft. The rides are free of charge and have increased patient accessibility to in office services.

- **Chronic Management Programs**

  - CareMore supports a proactive approach to chronic disease management aimed at minimizing the need for more expensive acute care services. Following a comprehensive medical screening, patients are enrolled in one of CareMore's many different disease management programs centered around their specific chronic needs. Patients are seen periodically in a CareMore clinic by their care team and monitored using disease-specific metrics to determine progress or if the patient requires more intensive care.

- **CareMore *Extensivist***
  - CareMore utilizes *Extensivist* physicians who coordinate hospitalized patients and support transitions between hospitals, CareMore clinics, nursing facilities, or other sites of care. The Extensivist holds a leadership role within the patient's care team, connecting CareMore PCP's, nurse practitioners, medical assistants, and case managers.

Results

- CareMore has reported an overall 18 percent reduction in costs compared to the Medicare FFS industry average.
- Average inpatient length of stay is 3.7 days compared to a Medicare fee for service (FFS) average of 5.2 days.
- Average bed days per 1000 is 48 percent lower than Medicare FFS.
- End-stage renal disease hospital admissions are 50 percent lower.
- Diabetic amputation rate is 67 percent lower than national averages.

Case Study #3: In 2013 Lahey Health implemented Guided Health – a home based care program that aims to improve health outcomes and reduce spending by better managing care for aging adults with multiple chronic conditions. The organization enrolled 40,000 elders in an accountable care organization (ACO) contract with Medicare and targeted the most at risk patients to participate. The model uses registered nurses to assess patients' needs, create care plans, and teach patients how to manage their conditions.

Nurses take a six-week web-based training course to become Guided Care certified and work in collaboration with the patient's primary care provider. The training reviews common diseases among older adults and offers strategies to engage patients in efforts to improve health. Nurses monitor patient progress, manage transitions between care settings, and provide referrals to community services if necessary. Lahey Heath is one of 18 U.S. health networks that have implemented Guided Care to proactively manage high-need patients in outpatient settings.

The program targets the top 5 percent highest risk patients with 15 Guided Care nurses. These patients are identified by tracking hospital visits and diagnoses. Nurses serve between 125 and 150 patients with 1,500 patients served thus far. Program leadership cites Lahey's use of three pharmacists, three health coaches, and four social workers as to why nurses are able to manage large caseloads.

The Guided Care model is cited as a relatively inexpensive approach and comes with tools that can be modified to the needs of different organizations. They Include:

- An assessment form and health history questionnaire
- Guidelines for creating patient-friendly action plans and detailed care plans for primary providers
- A caregiver interview form, focusing on best practices for managing their time and resources

- Survey materials for patients and clinicians to assess the program's effectiveness

Needs Assessment and Care Planning: Primary care providers introduce Guided Care nurses to patients during an in-office visit and use this opportunity to build trust. The Guided Care nurse conducts a needs assessment documenting the patient's concerns, assess their function level, and develop a care plan. Care plans are written in plain language and provide all necessary contact information.

The assessment includes:

- Review of all diagnoses and lab values
- Medication reconciliation
- Depression screening and mental exam to check for signs of memory loss/dementia
- Review of home to address safety hazards and assess the level to which patients can perform basic tasks

After addressing patient concerns nurses focus on longer-term issues such as the patient's chronic conditions, coordinating good nutrition, and connecting them with other social networks.

Communication and Coordinating Care: Care teams meet regularly to review cases and work through problems, social workers handle issues such as housing and caregiver support, health coaches make efforts to engage patients and motivate them to improve their health, and pharmacists carefully review medications. Nurses are embedded in clinics enabling them to build personal relationships with physicians that facilitate care coordination. Care teams also coordinate with hospital care managers and schedule home visits following a hospitalization.

Lessons Learned:

- Determining the level of patient support is difficult; some patients require extensive oversight while some benefit from limited assistance.
- Efforts to manage chronic conditions improved quality of care but did not always translate into cost savings.

Results:

- From 2013 to 2014, Lahey's Medicare ACO members had a 22 percent reduction in hospital admissions and a 7 percent reduction in emergency department visits.
- The 2015 cohort was much sicker than in the previous years, but hospital utilization did not return to 2013 levels.
- Even with duties spread among care team members (physicians, nurses, social workers and pharmacists) Lacey has fallen short of its 5 percent goal and is currently managing the top 3 percent of highest risk patients.

Additional Reading

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Primary Care Modernization Complex Older Adults Design Group 1

Consumer Input, Questions and Concerns:

- Primary care physicians do not always understand complex, rare illnesses and so can't be gatekeeper for care. Managed care should be designed so PCP can manage the care across specialists, not be experts in everything.
- Communication between primary care physicians and subspecialists is lacking. This is often due to lack of shared data between the two, especially when they are in different networks and have different Electronic Health Record systems.
- Lack of care coordination in primary care – there is often a care coordinator for specialist care but not a link back to primary care
- Depression and alcoholism are rising concerns in the older population due to isolation and boredom and there typically aren't integrated services
- Older adults need to be their own advocates, but they need communication between PCPs and specialists to understand the full picture.
- 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 physicians because of how the system is designed. Support moving to new payment model that will address this.

Summary of Key Points:

The design group discussed the following capabilities within primary care to address these issues:

- Geriatricians helping to educate primary care providers in geriatric care, more focus on this in medical training to address workforce gaps
- 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
- 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
- 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
- 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 the primary care team.
  - Specialized in dementia care based on interest and training

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

Design Group Notes

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 PTTF, 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.

PCM Complex Older Adults Design Group 2

10/19/18

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.

PCM Older Adults with Complex Needs Design Group Meeting 3

11/06/18

Participants: Laura Roix, Joan Conley, Patrick Coll, Mark Schaefer, Stephanie Burnham, Linda Green, John Freedman, Alyssa Harrington, Ellen Bloom, Lesley Bennett, Patricia Richardson, Stephanie Marino

- Consumer: How do we ensure no duplication of coordination efforts?
    - How will this work simultaneously with other adults who also receive coordination services?
    - FHC: You have a care coordinator in the practice. Or, the practice would contract out.
- Consumer: Shared a concern over duplication of effort and duplication of funding
    - State: This effort will set up rules to ensure the care coordination we are funding in the practice doesn't duplicate what is already being funded
        - The supplemental payment is fluid, so it supports many services
        - The bundle is flexible and fluid
- One of the areas of greatest risk- care coordination based on a host of waiver services.
    - Would it be useful to have a clinical scenario- a patient story -that allows folks to understand how the care coordination might work?
    - It's a clinical scenario, though.
- State: I used to do assessments and care coordination. Its more of a clinical nature. There is confusion on the part of the beneficiary-it's not clear. People are coming in the home and they are not able to relay whose been there and why. A waiver service is going to be coordinating and there must be some support from the primary care coordination.
    - State: You're suggesting- in any -case the primary care provider should pay for those services?
    - State: It's confusing to the individual. All this effect the plan of care. Must make sure that care manager assigned to that individual is intricately involved
    - Provider: We don't have care coordinators per say, we have a social worker. We do have a nurse as part of our chronic care management. Its difficult to operationalize that. Somebody needs to understand they're the central person for coordinating care for this individual. Its mostly patients and patient family members who come to us. How can we incentivize this?
    - FHC: Doing population health analytics, outreach to the member, we have a capability on chronic pain management.
        - Either from the patient or provider recognizing the need- PCPs must talk to the family, and if needed, make a transfer over to the specialist in the area.
        - Provider: You must be aware there may be some sensitivities, providers don't have the resources to give these patients this or some might not know what they're doing
        - Consumer: When I did case management services, the response from the physician was very negative, for some it didn't matter whatever the circumstances

        - Consumer: From a patient standpoint, it's hard to find a physician group to coordinate when you're dealing with complex chronic illness, it's hard to find someone that can coordinate well
        - FHC: Primary care providers should be driving that?
        - Consumer: It's who the patient feels most comfortable with. It should be whoever is the best provider to be able to be giving the best guidance. Not all doctors are equal in a group setting, and that would limit their ability
        - FHC: Patient choice is in this effort. Patients can see whichever provider they want. Requirements of AN would have to have some kind of Center of Excellence on Aging. The network is responsible for making it known that that resource is available
            - Consumer: I am not in favor of a network, period.
    - State: for Medicare beneficiaries for fee for service, the PCM initiative is focused on individuals who are attributed to ACOs that are basically physician networks. Focused on improving capabilities of networks. The ACOs would say we have a few practices that specialize in the challenges of older adults with complex care needs, and you may find this is an option in other practice where they're in tune with the kinds of challenges you're encountering. Patients have total freedom of choice. The point is do we think its important for the network to have this capability?
        - Consumer: If there's high cost, how are you going to prevent an incentive to encourage people to go elsewhere for services if they're finding that bundled payment is too expensive for that practice?
        - State: So, we are not talking about health plans.

Revised Concept Map for Primary Care for Older Adults with Complex Needs

- FHC: Reviewed provided diagram.
    - Is this a capability all networks should provide?
- Role of subspecialists-other opinions on why there needs to be a primary care provider for that patient
    - Provider: It's not just acute episodic care.
    - Another provider: Yes. It is system-specific, it is related to the patient's issues. Most primary care physicians would agree this is based in primary care. I think it makes a lot of sense to have a true primary care physician to help coordinate care for them.
    - Consumer: Cardiologist is a good example. There are times when other systems come into play (spinal cord injury, MS, brain injury, central issue) that are being addressed and it doesn't always mean the specialist is centrally located. Most of the time, that specialist ends up being the main coordinator of care. This is important because other health issues must be factored in when introducing new medication, and, for example, that cardiologist (i.e. specialist) would not necessarily be coordinating all their care.
    - FHC: We want to make sure patients have the choice to choose their care through a subspecialist to get paid fee for service. And if the patient didn't have a PCP at all because they only see their subspecialist, they wouldn't have to change providers and that specialist would get paid as a PCP

- Provider: You're going to want PCP providers to continue to provide preventive care, immunizations, cancer screenings
- State: It's important we find a way to describe this, not limiting freedom of choice. Not to limit freedom of choice but to understand the focus of PCM is because of the unique and critical roles they can potentially play into the care of all patients. In the disabilities group meeting, this came up as well.
- Provider: In PC, it's not like it's a default specialty, primary care is its own type of practice.
- FHC: There needs to be a PCP to address those other needs.
- FHC: Primary care is absolutely its own specialty.

Next Steps:

- Develop some of the language around care coordination (i.e. a patient could choose to see a specialist in geriatrics while seeing a PCP)
- Provider: Is there any element of shared savings model like the Independence at Home project. Taking them out of the most expensive parts of the primary care system
  - State: Was that for individuals who were dually eligible?
  - Provider: You had to have two or more medical conditions. You had to have been discharged from a hospital setting, so you had enrollment criteria. Medicare knew what the overall costs would be for this type of patient population. any element of that in the program?
  - State: I would have to look carefully in how that program is structured. Today, any Medicare beneficiary is attributed for those and any patients able to achieve a reduction. I'd like to respond to the group with an answer in writing once I've taken a look at that program.
  - Provider: Fee-for-service has never served primary care particularly well. It must be tied to a reimbursement model. We've been trying to operationalize those. It's good care. Its good practice. But dedicating time and resources to it is too hard and burdensome to set it up. A system like this makes so much sense; you've got to really give a lot of thought in how to incentivize providers and how it makes sense for their practices
  - State: That's helpful. I think that the basic arrangement of giving practices the money up front to invest in things like care teams in the home. One of the problems generally is many physicians are part of larger systems not as deeply invested as they're in avoidable use. You're saying the incentive needs to be there
    - State: What's missing with regard to the incentive for the practices to participate in this model?
    - Provider: There may not be anything missing. I don't fully understand the reimbursement mechanisms behind this, but I do believe where and when you can allow PCP to share in the savings in the care coordination, they do. Where and when you can allow them to share in those savings, the model will be more sustainable
    - State: Independence at Home is a reference we should just make sure there aren't capabilities that are a focus of Independence at Home which is designed

for patients with chronic illness and a multitude of care management needs. We'll circle back and will make sure we cover that base.

- State: Circle back with proposed design that will go to the task force. In that process we may call out a feature from Independence at Home. And design group members can approve or disagree and then it will go on to the Task Force. In the circle back with adjustments, I can talk about how the payment model and Independence at Home is similar to what we're doing here
- Consumer: For the individuals that are selecting this PCM (who they're selecting as a PCP), the choice is not with the beneficiary or with the patient themselves, by virtue of selecting a provider, it's the provider participating in this that would decide whether the patient would be receiving this?
- State: The Medicare shared savings program-if you're choosing an MSSP provider, you're attributed under the model, you do have an option to opt out of data sharing, with regard to this primary care modernization, those same practices participating in MSSP, the network would opt to participate in the PCM complimentary program if you will. Their payment model would change based on patients attributed to them. We haven't discussed any issues around whether patients would be attributed to MSSP, but elect not to participate in PCM
- Consumer: People do not understand what's driving this is the payment structure
- State: It's too early to design member communications, it's important to flag this as one of the materials that would need to be developed to ensure Medicare beneficiaries are informed
- Consumer: Systematically underserving patients is a concern.
- State: We'll make sure providers develop approaches vs person-centered needs rather than payer preferences. The downside is also true if someone is systematically underserving patients as a strategy
- Provider: Patients who might not otherwise be on their way to a nursing home, skilled nursing care, long-term care -the Pace program-anything similar built into this?
- State: Pace extends beyond dual eligible.
- Provider: We don't have a pace provider in CT. Medicare is not on the hook for long-term nursing home costs.
- Consumer: Medicare network of providers convey a geographic region almost like a special needs plan but not designed to meet skilled nursing level care I think, it's just a model of providing care under Medicare
- State: The avoidable use when you better serve patients with complex care needs in the community, a group that's Medicare only, and then there's the group dual eligible today. the idea that we can surface to Medicaid is this question of creating an opportunity for the duals who are attributed, for there to be a shared savings payment. When you avoid both Medicare and Medicaid costs, is there a way for the beneficiary to benefit from some of these savings. Its complicated to do that and there are duals initiatives around the country to do that. Its cost advantageous to keep someone in the community usually. We can flag that as something that can be considered as a policy objective with DSS.
- FHC: For Pace, you don't have to be a dual. You need to meet nursing-level facility for that level of care.