OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization
Older Adults with Complex Needs
Design Group Meeting

October 2018

Agenda

Introductions	5 minutes
Overview of PCM and Purpose of Design Group	15 minutes
Discussion of Approach to Older Adults Capability	60 minutes
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

Building the Primary Care System We Need

What challenges does primary care face today?	How has "the system" tried to fix them?	What if we had?

Lack of coordination , convenience

Too little support between visits

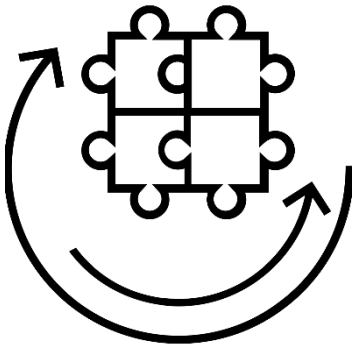
Too little money spent on primary care and providers are only paid for office visits.

Not integrated with behavioral health, substance use disorder, community resources

Ask providers to invest in "care transformation" without paying them for it

Put more burden on consumers to "engage" without sufficient support

Care teams to keep people healthy, catch problems early and manage conditions



Technology to connect providers with each other and their patients

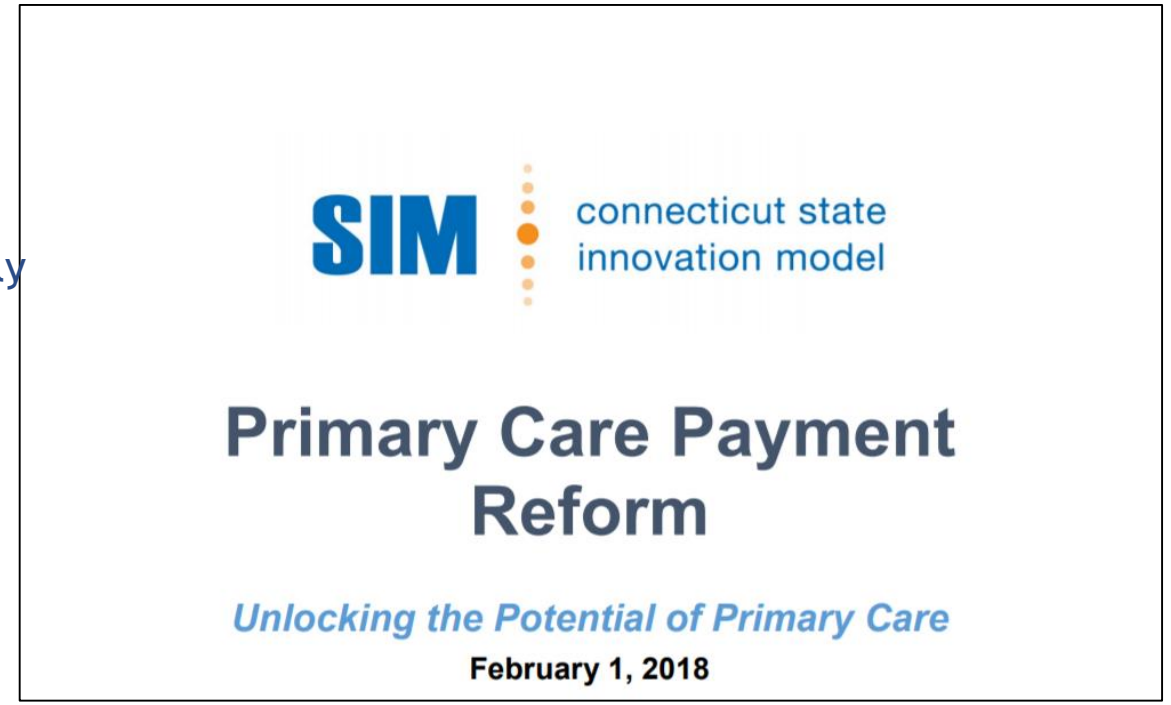
More convenience like options for email, phone, text

More investment in primary care and payments not tied to office visits

Primary Care Modernization: The Work To Date

Stakeholders have identified many goals for a new model of primary care in Connecticut, including:

1. Support patient-centered, coordinated care and a better patient experience.
2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed.
3. Expand care teams and improve access outside the traditional office visit.
4. Double investment in primary care over five years through more flexible payments.
5. Reduce total cost of care while protecting against underservice.



Payment Model Goal: Increase spending on primary care, reduce total cost of care, prevent underservice

Upfront, flexible payments offer a financial reason to provide the most effective, efficient and convenient care.

When Providers Are Paid Today

When Providers Aren't Paid Today

To make sure all patients achieve their best health, we can:

- Adjust payments to account for the different needs of patients
- Measure utilization and look for trends that suggest lack of access
- Make providers more responsible for long-term health outcomes

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?

- Primary caregivers (e.g. family members) need more support managing care needs.
- Older patients need an expanded range of support services that go beyond traditional in office care.
- Older patients face barriers to care including 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.
- Family members/caregivers must take time off from work to transport to medical appointments or alternatives to Emergency Departments for after-hours and weekend urgent care.
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients
- Desire to keep existing physicians and have physicians across systems communicate better with each other
- Need single coordinator that is focused on them (sometimes there are too many)
- Email, text, telemedicine – might not always work well for them – different seniors need different options
- Need pharmacists, more community health workers to get connected to community programs and interpreters
- Longer visits to address multiple issues and more time with physicians talking with them instead of typing notes

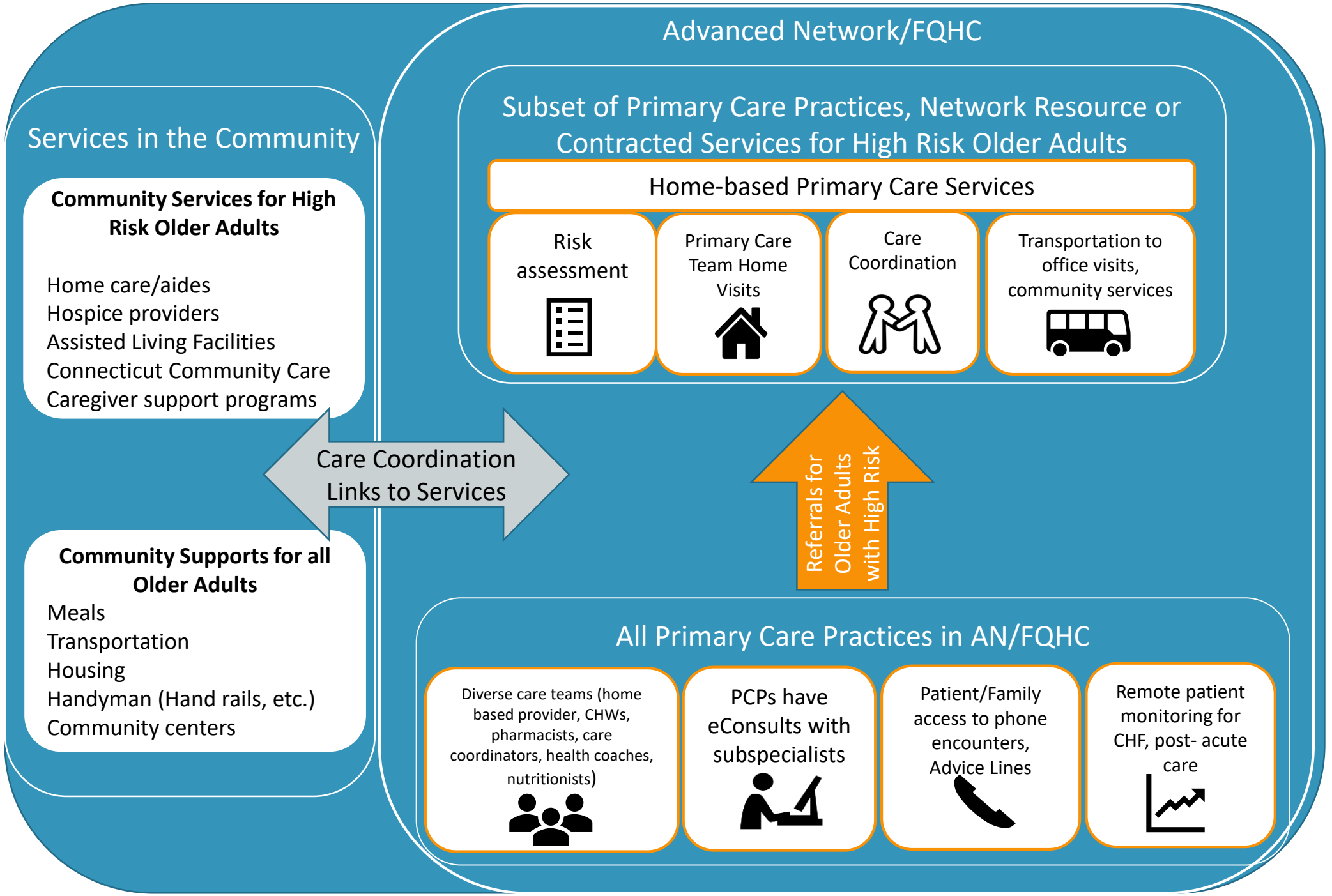
Older Adults with Complex Needs

Definition: Integrated home and community-based services and supports in primary care for high risk aging patients (over age 75). High risk patients 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.

Capability Requirements

- Diversified Care Teams
- Consultations with Subspecialists
- Phone/text/email encounters and telemedicine visits
- Remote patient monitoring as appropriate
- Home-based Primary Care (subset of practices or network resource)
- Potentially: Specialized care such as dementia care, end of life and palliative care (subset of practices or network resource)

Draft Concept Map for Older Adults with Complex Needs



Key Questions for Design Group

- Are there other capabilities all primary care practices need to better care for older adults?
- Should home based-primary care services be provided by a subset of practices, a centralized team within the network, and/or contracted services?
- What role should primary care have in providing specialized care for special populations or needs? How should specialty care be provided (subset of practices, network resource, connections to Centers of Excellence)
  - Care for patients with Alzheimer's and dementia
  - Care for patients with frailty
  - End of life and palliative care
- Should there be specific requirements for which care team members are part of the home based care team?
- Does the Design Group have specific recommendations about how to measure outcomes?

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)