CT Primary Care Payment Reform
Draft Capabilities Skeleton: Care for Older Adults with Complex Needs
This Draft: October 4, 2018

Scope and Purpose of the Design Group

Thank you for joining the conversation about Primary Care Modernization in Connecticut. The Practice Transformation Task Force is currently reviewing the capabilities that should be incorporated into a primary care payment model.

The purpose of the Design Group is to consider whether the capability should be included in a primary care payment bundle. During the Design Group meetings, we will have an opportunity to confirm the group's understanding of the proposed approach within primary care and the option's overall impact in terms of better health, better care, patient experience, provider satisfaction and cost. With a shared understanding of the capability, the group will also consider whether the capability should be elective or required and, if so, how it should be delivered – by all practices, by some practices, by the network, or some combination. The Design Group's conclusions will be presented to the Practice Transformation Task Force, which is responsible for making a formal recommendation to the Payment Reform Council (PRC).

Some considerations to keep in mind:

- The CT SIM primary care payment initiative is directed at provider groups that participate in shared savings contracts and the pediatric practices within those groups.
- The payment model will include recommendations about risk adjustment (so that providers are fairly compensated for populations with higher needs) and attribution methodologies.

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.

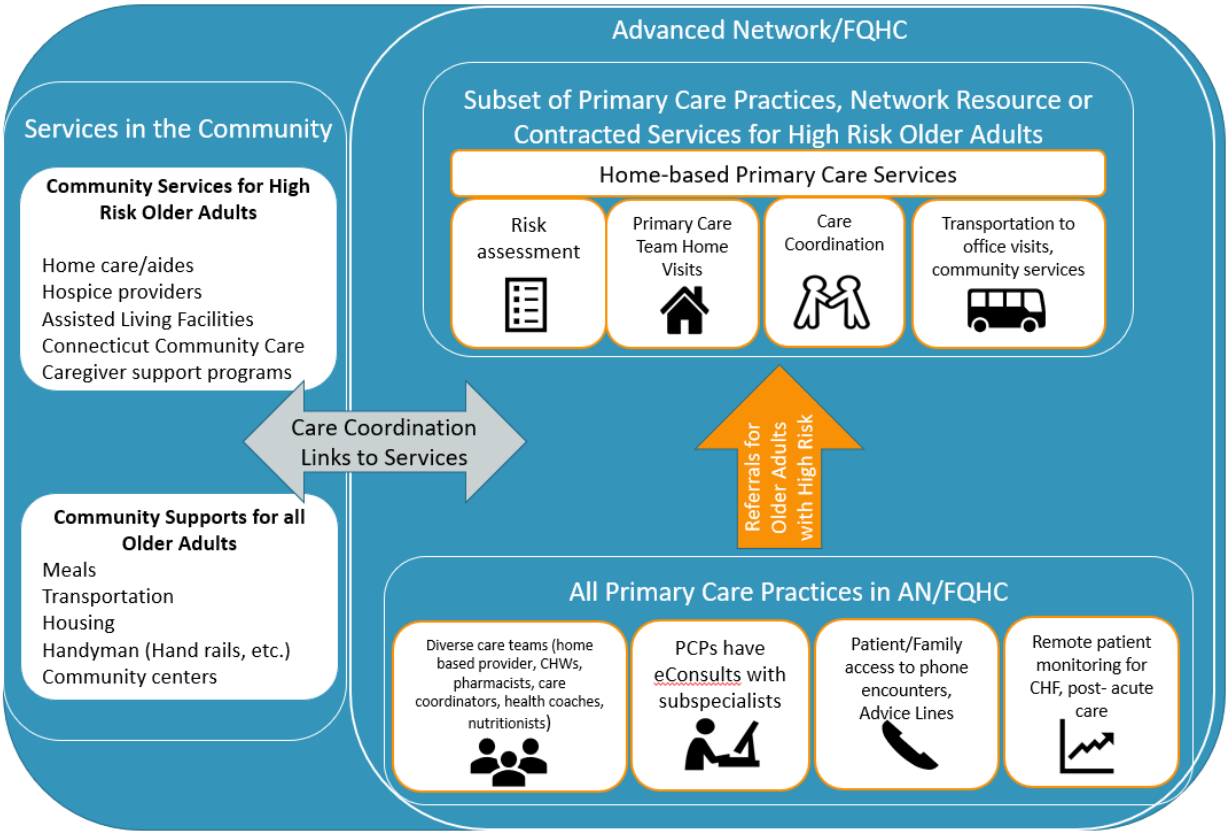
Proven Strategy

Name: Enhanced Primary Care for Older Adults with Complex Needs

Definition: 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.

Goal: Increase primary care practice and network capacities and resources to provide specialized care for older adults with complex needs.



Capability Requirements

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

- **Diverse Care Team**[1]: 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 will need to be cross trained in geriatrics care and/or supporting older adults through community supports (depending on if they have a clinical or non-clinical function), along with their other functions. 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

[1] 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.

to care and manages the patient's conditions by providing preventive services and routine 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 within the network. E consult 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.

- **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 providers within the network offer specialized services for high-risk older adults with complex needs:

- **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 and patient navigation involves deliberately organizing patient care activities and sharing information among all members of the care team. Care coordination may be performed by a member of the primary care team and/or a member of the home-based primary 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.
- **Transportation:** Transportation services are provided to patients who have difficulty getting to in-office appointments or community services. Transportation services may be owned by the health network or contracted to a third party. A member of the patient's care team, most likely the home care provider or a community health worker, schedules and coordinates transportation services ensuring continuity of care between all providers.

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 Needs:

- 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

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.

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