OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization
Older Adults with Complex Needs
Design Group Meeting

November 2018

Agenda

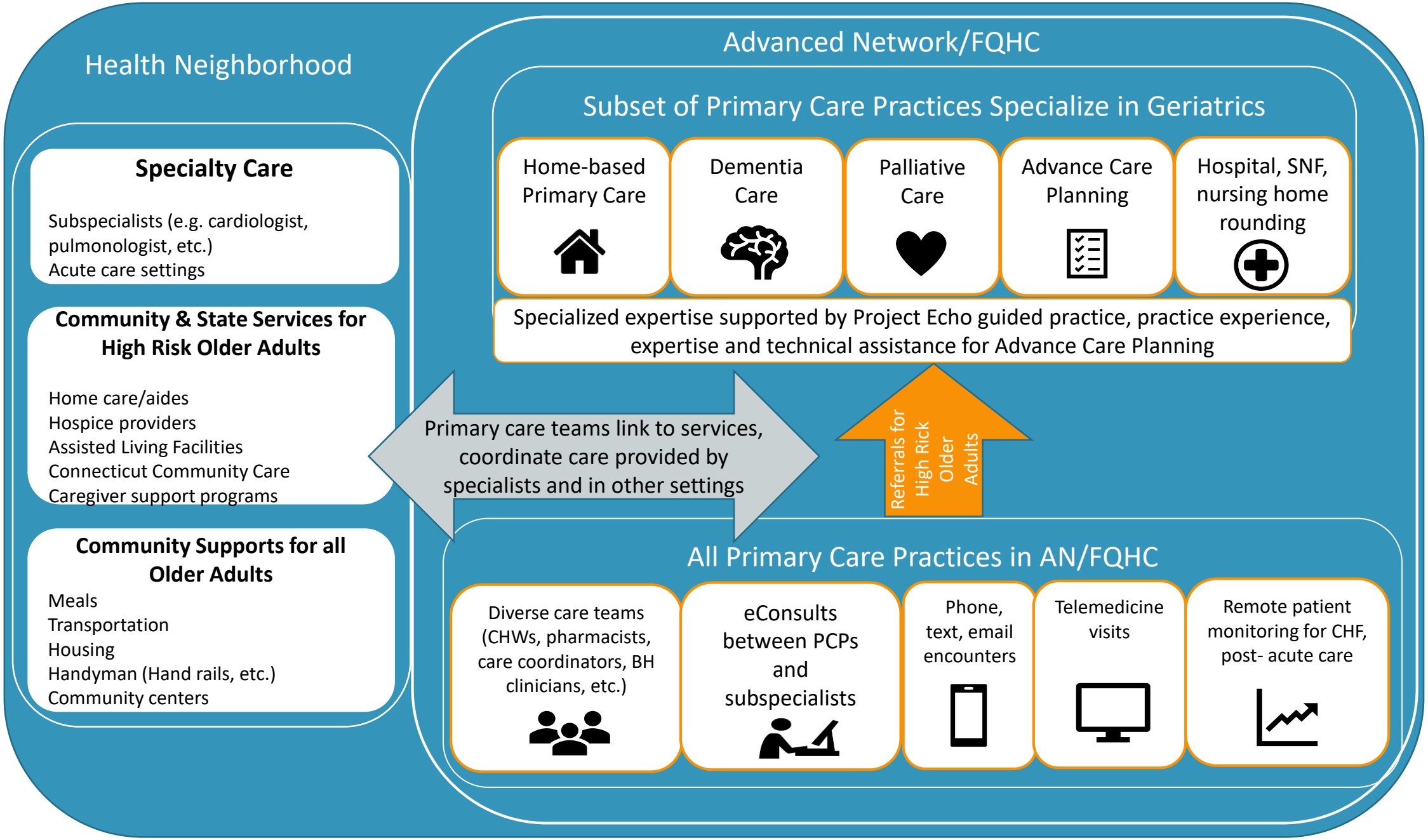
Introductions	5 minutes
Discuss Questions Raised in Previous Session	70 minutes
-Role of Subspecialists	
-Implementing the Capabilities	
Sense of the Group	10 minutes
Next Steps	5 minutes
Adjourn	

Questions for Discussion

Questions raised in the last session for further discussion:

- What is the role of subspecialists (e.g. pulmonologists, cardiologists, etc.) in providing primary care for older adults with complex needs?
    - What happens if someone is not attributed to a primary care provider?
- How will these capabilities be implemented in practice? How do we know providers will follow these best practices?

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



Patient Perspective

Sally is 75 and lives at home alone. She has diabetes and her family is worried she may be showing signs of dementia. She sometimes forgets conversations she just had and recently forgot how to get to the grocery store. She also has trouble figuring out which medications to take when. She was recently hospitalized from chest pain and shortness of breath, and is being treated for heart failure.

Sally's son makes an appointment with a primary care practice specialized in geriatrics

At her visit, the PCP assesses her for dementia, and talks to her and her son about her conditions.

A nurse care manager, gets her medical records from the hospital, her cardiologist and her endocrinologist.

The nurse care manager helps develop a care plan, schedules a home visit with a pharmacist, and refers her and her son to dementia resources in the community.

Her PCP has eConsults with specialists about her care plan for diabetes and heart failure.

The pharmacist and care manager visit Sally at home and help organize her medications and set up a reminder system. They also give her information about OTC medications that interact with her medications.

The care coordinator follows up with Sally's son about finding dementia resources and schedules a follow up the next month to check on her diabetes and HF.

Next Steps

- Incorporate today's feedback and circulate to design group
- Task Force reviews and makes recommendation to Payment Reform Council (PRC)

Appendix

Task Force Considerations for Including Subspecialists as PCPs in PCM

The Task Force recommended that subspecialists are not eligible for participation in PCM after considering the following:

- Patients will always have the freedom to choose to have their primary care through a subspecialist. The subspecialist is paid Fee For Service for primary care services for patients attributed to them.
- Subspecialists have a limited number of patients for which they provide primary care, which will make it difficult to transform their practice for this small subset.
- Research suggests subspecialists 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.[1]
- Providing primary care via subspecialists is likely to increase costs as subspecialists are likely to have higher negotiated rates for E&M visits.

1 Lakshmi, S., Beekman, S., Polgreen, P., Rodriguez, A., & Alcaide, M. (May 2018). HIV primary care by the infectious disease physician in the United States- extending the continuum of care. AIDS Care, 569-577; Cheng, Q. J., Engelage, E. M., Grogan, T. R., Currier, J. S., & Hoffman, R. M. (October 2014). Who Provides Primary Care? An Assessment of HIV Patient and Provider Practices and Preferences. Journal of AIDS and Clinical Research, 366.

Common Capabilities from Successful Primary Care Models for Complex Older Adults

Primary care practices using intensive team-based care models to target high risk seniors show evidence of reduced hospital admissions, length of stay, and readmissions and improved patient experience. Common capabilities include:

- Multidisciplinary care teams
- Longer visits and smaller patient panels
- Same-day or next day appointments
- Addresses social determinants of health
- Care coordination in hospital and care transitions
- Behavioral health integration
- Customized electronic health record systems that focus on clinical issues rather than billing

Source: Modern Healthcare: https://www.modernhealthcare.com/article/20181020/NEWS/181019908?utm_source=modernhealthcare&utm_medium=email&utm_content=20181020-NEWS-181019908&utm_campaign=hits

Case Studies

- **Commonwealth Care Alliance**: Senior Care Options intgrated, team-based approach including home visits and care coordination for people who are dually eligible for Medicare/Medicaid and are nursing home eligible. CCA reports:
  - 4 out of 5 stars for 2019 CMS Services Star Ratings
  - 27% reduction in acute admissions per 1,000 from 2011-2017
  - 5.7% reduction in 30-day readmission rate from 2012 - 2017

- **CareMore**: Targets high-risk, chronically ill patients using hospital extensivist model to provide team-based care coordination and disease management during hospitalization and care transitions. CareMore reports:
  - Lower 30-day hospital readmissions rate than for overall Medicare population (13.6% v. 19.6%)
  - Members' per capita health spending was 15% less than the regional average
  - Hospital length-of-stay was shorter: 3.2 days compared to 5.6 day average in Medicare fee for-service

- **ChenMed**: High intensive team-based primary care for seniors with multiple conditions. A recent evaluation conducted by ChenMed and the University of Miami found[3]:
  - Increased primary care physician visits and use of preventive medication
  - Reduced hospital admissions than standard Medicare Advantage primary care patients
  - Reduced per member per month costs than standard Medicare Advantage primary care patients ($87 v. $121)

[1] Commonwealth Care Alliance Fast Facts. http://www.commonwealthcarealliance.org/about/cca/fast-facts-about-cca

[2] AHRQ Healthcare Innovations Exchange. https://innovations.ahrq.gov/profiles/medical-extensivists-care-high-acuity-patients-across-settings-leading-reduced-hospital-use

[3] Ghany, R., et al. Am J Managed Care. 2018;24(9):e300-e304 https://www.ajmc.com/journals/issue/2018/2018-vol24-n9/hightouch-care-leads-to-better-outcomes-and-lower-costs-in-a-senior-population