



## The Frail Elderly Project



**This effort has been generously funded by the  
Vermont Health Care Improvement Project**

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## Executive Summary

The Frail Elders Project was undertaken in order to promulgate actionable recommendations for improving the primary care delivery system in Vermont. The project team chose to focus on frail and high-risk seniors knowing: 1) care could be better; 2) improvements could potentially effect multiple practice and community services; and 3) recommendations could be generalized to other patients and communities. The project team purposely did not choose to focus on individual diagnoses, as is often the case in health reform efforts. They wanted a broader impact. They wanted to foster a rethinking of primary care. They wanted to create a reform paradigm in which payment innovation serves practice innovation, with things that matter to patients as the paramount driver of reform; a reform paradigm offering hope for the future of the practice of primary care in our rural communities.

As the project matured its scope, it was broadened to include all seniors at risk of poor health outcomes or a decline in the quality of their lives. Those seniors that already meet the clinical criteria of frailty are still included, but the project team and all those that contributed to its research feel strongly that preventing or delaying frailty is equally important as caring for those already frail.

Underlying project recommendations are findings that are remarkably consistent across all sources of information:

1. There are mismatches between what gets paid for and what's important to seniors;
2. Today's payment policies create significant inefficiencies and harm Vermont's seniors;
3. Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
4. Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
5. When possible care should go to patients rather than patients having to come to care;;
6. Control over health care budgets needs more community level influence;
7. Primary care is in critical condition, and we all need to rethink how to support it;
8. There are proven examples of how to do it better; and
9. There is a lot that can be done right now!

Our recommendations are all founded on what we were told by seniors, by community based clinical practitioners and support service providers who aid the elderly every day, by Vermont subject matter experts and from a review of published literature with the assistance of our University library system. The recommendations are our sincere attempt to design a care model that reflects what we were told or has been published in the peer-reviewed literature. We anticipate and encourage serious discussion about our recommendations. We also encourage efforts to increase the breadth or depth of our research where needed. That being said, we hope that discussion and subsequent policy will not spin away from what seniors say matters to

them and the knowledge of their caregivers who know them so well. The reader is encouraged to read the four sets of research findings as they are rich in nuance as well as actionable detail.

### **1. Who are our high risk seniors?**

Both the project's literature review and key informant interview study found that frail and high-risk seniors are characterized by having multiple chronic conditions, functional impairment, impaired mobility, gait and balance problems, cognitive impairment, and depression. In addition, this subset of seniors frequently has high utilization of health care and social services. They are also more likely to be low-income, live alone, lack caregiver availability, and lack an adequate support system of family and friends. Key informants universally identified social determinants of health as critical factors in the well-being of seniors.

A three-step identification process is recommended. Initially, existing data such as billing data and structured data in medical records for all patients known to a practice should be analyzed by a predictive algorithm. Identified patients are then risk stratified based on significant events, high utilization patterns, key diagnoses, social determinants of health and impairment in ADLs and IADLs if available. The resulting list of identified patients should be reviewed for appropriateness by a dedicated practice seniors' care team. Subsequently practice team members can recommend additional patients known to them to be at risk of poor health outcome or a decline in the quality of their lives. All partner community support service providers are invited to recommend additional people in the community.

### **2. How will we measure success?**

A multi-dimensional balanced evaluation is recommended. No single index of success is sufficient. Existing validated metrics should be used when possible and directly relevant to the process or system being evaluated. Annual ongoing comparisons to appropriate benchmarks should be utilized rather than pre and post measures. The evaluation should include measures in the following domains:

- Social, clinical, mental health, substance use and healthy behaviors (diet, exercise) as it relates to a person's ability to maintain or improve their health
- Functional measures including patient reported outcomes such as activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Measures of patient goals being met
- Measures of independence with sufficient self-management support
- Provider reported process and outcome measures directly related to the systems of care and the care needs of this population of patients
- Utilization and financial measures including hospitalizations, ED visits, long term nursing home placement and claims paid

### **3. How will we care for them?**

Each senior in the high risk group will have a comprehensive initial assessment by the practice's multidisciplinary Primary Care Team. Key members of the Team will be the primary medical practitioner, a practice nurse, the practice's integrated care coordinator and the patient and/or

their caregiver. The assessment will include a visit to the patient's home and a discussion of needed home based services to support independence. Based on the assessment every high risk senior will have a Care Plan with guidance for the patient, for the family and for both clinical and community support providers.

Outside of the practice, but including key representatives of the practice team, will be a Neighborhood Team. The Neighborhood Team will include representatives of appropriate community support and service providers with the patient and family's consent. The Neighborhood Team will meet with sufficient frequency to review new and emergency cases as well as periodic reviews of all high-risk seniors in the community. Patients and families will always be able to choose not to have their Care Plan discussed outside of the practice; their privacy concerns will be respected.

A third layer of community coordination will occur at periodic meetings of representatives of both practice and community partners. This tertiary level of coordination will focus on the adequacy of the overall needs of the community's seniors and available local, state and federal resources and serve as a focus for community advocacy for their senior citizens.

#### **4. How will we pay for their care?**

While the design of a financing system must follow design of a delivery system, financing can have a strong effect on all aspects of system performance, including patient and provider satisfaction, quality of care, and value. We recommend that the payment model be focused first and foremost on addressing what matters to the patient. Evidence shows that what patients want is not always reflected in the current health care system. It should recognize the risk of patients being cared for in a more comprehensive way than current risk-adjustment methodologies do. It should permit the use and coordination of a broad range of services, both medical and social. There is an increasing body of evidence that appropriate use of social services can reduce the need for higher-cost medical interventions.

Several funding mechanisms are in operation in the US and Canada that support parts of the recommended care model. None of them support all the components of the recommended model nor do many of them cast a wide enough net to capture all the high-risk seniors in our rural communities. Two programs are presented to highlight key issues: 1) The Commonwealth Health Alliance's Senior Options Program; and, 2) the CMS demonstration project, Independence at Home. We are highlighting these two programs because they are in operation presently, demonstrate remarkable success in delivering care in a manner that matters to seniors and illustrate the potential for innovative care models and payment policy. The reader should be cautioned that eligibility for both these programs is directed at seniors with either the most limited financial resources or a very high need of clinical care. If these programs were to be implemented as is in the two target Vermont communities, many seniors would be left out. However, elements of both these programs, if adapted to address the needs of Vermont's high-risk seniors, would be an improvement over the status quo.

A more profound suggestion is a monthly bundled risk adjusted population health payment for this subset of patients with incentive on outcomes important to patients within a larger all payer model system as might be conceived in Vermont in the near future. This model would be unique to Vermont and could be part of the larger Medicare waiver program. Program management could be accomplished through the evolving accountable care organizations landscape.

The paramount issue about payment is that a payment methodology should be the last question to be addressed. What matters to seniors as presented in the project findings needs to always be of primary importance and the final guide to any decisions about care model design, measures of success and funding mechanisms to support care.

As mentioned, our recommendations are based on the key findings from seniors themselves, practitioners who know them so well, subject matter experts and a comprehensive literature search. There is no existing system of care exactly like the proposed model; however, every component exists elsewhere, and most have been rigorously evaluated by independent qualified experts. Taken together, our recommendations outline a new model of care that is driven by the priorities identified by the seniors in our communities; and can be expanded to other special populations of Vermonters and other community based primary care settings.

A prominent ubiquitous theme in every research arm has been the critical condition of primary care in our rural communities. We all need to rethink how to provide quality primary care in our state. The Project Study Design and Recommendations target making things that matter to seniors better, but the authors also hope that, if implemented, the recommendations will help ease some of the strain on our rural primary care practices. The recommendations purposely attempt to move care to the patient, and by doing so hope that care will not only be more in line with patients' wishes, but that it will make our rural practices more efficient, the burden of documentation and measurement more transparent and meaningful and bring more professional satisfaction and joy to the primary care workforce.

The project has had funding from the Vermont Health Care Improvement Project between November 2015 and June 2016. Earlier support was generously offered by the Physicians Foundation of Cambridge, MA and Vermont's Green Mountain Care Board.

This report and all of the supporting research reports can be accessed on the project web site <http://www.vmsfoundation.org/elders>

## Introduction

In 2012, a small group of primary care practitioners began to discuss ways primary care practitioners in Vermont could improve the primary care delivery system across the state by providing better, more coordinated care and improving the workplace for the primary care workforce. The context for the initial conversations were the early phases of an aggressive health care reform effort at the state level, a growing sense of the need for more coordination and

integration of medical care with community support services and emerging frustration within both the medical and community support services with change being forced on them from the outside rather than change being led from inside of the communities.

Initial support for the effort was a physician leadership grant from the Physicians Foundation of Cambridge, MA <http://www.physiciansfoundation.org/> Subsequent support was a contract with Vermont's Green Mountain Care Board, the deliverable of which was to suggest to the State appropriated goals for the State's Health Resource Allocation Plan which gives the Board authority to allocation medical resources justly across the state. The result of that contract were two Whitepapers, <http://www.vmsfoundation.org/news/foundation-presents-whitepaper-physician-opinion-optimizing-hospital-based-care-gmcb#overlay-context=reports-whitepapers> and <http://www.vmsfoundation.org/news/foundation-presents-rural-care-whitepaper-gmcb> . Both papers were enthusiastically received by the Board. The Board asked the authors to propose a project with actionable recommendations. The Frail Elderly Project was subsequently designed.

At its inception, the scale and scope of the project were small and focused principally on addressing barriers and improvement opportunities more medical than community service based. The proposal was reviewed by an initially skeptical audience. As a result of the broad public critique and input, the proposal was modified and eventually gained universal support from all interested partners. The project was subsequently awarded a \$140,329 grant from the Vermont Health Care Improvement Project in November 2015. The Project was awarded an additional \$11,500 in March 2016 in order to expand the scope of the literature search analysis and patient particularly home-bound individuals. A report and presentation of its findings and recommendations is due in June 2016.

The key to the project's survival was the insight of its initial proponents to always keep it focused on what matters to patients. Eventually, a culture of trust grew around the effort and it has received extraordinarily generous support from everyone involved in the discussions about its relevance and importance.

The principals of the Project Research Team expect and hope that their findings and recommendations will be seriously discussed and improved as a result. The Team hopes that when there is controversy over a recommendation or next step that the intent of the decisions on how to move forward will always be measured by whether they make things better that matter to patients.

## Project Design

This qualitative research project was carried out by a nine-person multidisciplinary research team: Josh Plavin MD MPH, Brian Costello MD, Nancy Bianchi MSLIS, Fay Homan MD, Milt Fowler MD, Erica Garfin MA, Steve Kappel MPA, Randy Messier MT MSA PCMH CCE and Cyrus Jordan MD MPH.

Team leader Cyrus Jordan met regularly with a designated project manager from the Vermont Health Care Improvement Project (VHCIP). The VHCIP contract is with the Vermont Medical Society Education and Research Foundation (the Foundation), a non-profit public benefit corporation recognized as a 501© (3) corporation by the IRS. All members of the Research Team are independent sub-contractors to the Foundation or independently contracted by VHCIP to offer technical support to the grantee.

The project is purposely limited to the Little Rivers Health Care Primary Care Service Area (PCSA) and the Gifford Health Care PCSA. Little Rivers Health Care has health centers in Wells River, Bradford, and East Corinth. Gifford Health Care has health centers in Randolph, Bethel, Chelsea, and Rochester. Both Little Rivers and Gifford are Federally Qualified Health Centers (FQHCs). Both these communities are rural. Their principal hospitals are both critical access hospitals. The FQHC provides the vast majority of all medical services in the communities.

The Project utilized four methodologies to accomplish its objectives:

1. A literature review
2. Analysis of Vermont and federal survey data
3. Focus groups and interviews with seniors and their caregivers/surrogates
4. Structured key informant interviews with health care providers, community-based service providers, and policy experts.

#### **1. Literature review**

The literature review was conducted by Brian Costello MD with the contracted assistance of Nancy Bianchi MSLIS at the University of Vermont Dana Medical Library.

#### **2. Analysis of Vermont and federal survey data**

The data analysis was conducted by Policy Integrity, LLC. Two surveys were analyzed: the federal Medicare Current Beneficiary Survey (MCBS) and the Vermont Household Health Insurance Survey (VHHIS). Each of these can provide useful information but their value increases substantially if their information can be combined. The MCBS is a national survey, containing a wide range of information on Medicare beneficiaries, including both utilization of medical services, health status, specific chronic diseases, and ADLs (activities of daily living). Because it is a national survey, too few Vermont residents would be included to allow for any analysis. VHHIS is currently managed by the Vermont Department of Health.

#### **3. Focus groups and structured interviews with seniors and their caregivers/surrogates**

Focus groups and interviews with seniors and their caregivers were conducted by Brian Costello MD. Informants were recruited by the target practices and community support service providers.

#### **4. Structured key informant interviews with health care providers, community-based service providers, and policy and content experts**

Structured key informant interviews were conducted by Erica Garfin Consulting. Two physician leaders who were part of the Frail Elderly Project Team identified and recruited key informants in their respective communities.



Community-based informants were drawn from a variety of fields: primary care (physicians, nurse practitioners, physician assistants, nurses), mental health/substance abuse, home health, hospital discharge planning, care coordination, quality improvement, Blueprint for Health, Support and Services at Home (SASH), adult day program, area agency on aging, senior center and clergy. A state advisory panel to the project identified key informants from the arena of geriatrics and aging who could provide policy and content expertise on the systems level.

The Research Team developed a set of consensus foundational constructs to guide the project: a target population, a project global aim and 10 research focus areas:

### **Target Population**

Seniors at risk of a decline in the quality of their lives or a poor health outcome.

### **Project Global Aim**

We aim to identify barriers to providing the best primary care for high-risk elders in two rural communities and recommend:

- 1) Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients;
- 2) Payment innovations to support the redesigns; and
- 3) Measures to track changes in outcomes that matter to patients.

By undertaking this effort we expect to increase the value of the health care system – focusing on outcomes that matter to patients, reducing harm, conserving resources and increasing system efficiencies.

It is important to work on this now because as health care professionals we can play an important role in health care reform by designing more patient-centered, efficient and high value care. Redesigning how high-risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high-need population while decreasing the cost of care for the target population.

### **Research Focus Areas**

The research was guided by the following questions:

1. What characterizes a frail or high risk senior?
2. What are the characteristics of their service utilization?
3. What matters to seniors?
4. Are there care models known to produce better value (outcomes/cost)?
5. What systemic barriers to providing care exist?
6. What aspects of the delivery system are and are not working locally?
7. How could the local delivery system be improved?
8. What are practical and meaningful measures of value? (things that matter to patients/cost of meaningful episodes of care)
9. What are unnecessary costs and how could they be reduced?

## 10. How can payment reform support the achievement of things that matter to patients?

The Research Team used a consensus approach to promulgating the recommendations. The recommendations are based on the Team's analysis of the aggregate findings. All recommendations reference the findings on which they are based.

## Findings

The research effort was based on five separate sources of information:

- A literature search in partnership with the University of Vermont Dana Medical Library;
- Key informant interviews with community-based health and supportive service providers in two rural primary care service areas;
- Key informant interviews with state policy and subject matter experts;
- Structured interviews with frail elders and their caregivers including home bound individuals in two rural primary care service areas, using both individual interviews and focus groups;
- Comparative analyses of the Vermont Household Survey and the Medicare Current Beneficiary Survey.

The findings are presented in four discrete research reports:

1. **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review;**
2. **What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review;**
3. **Caring for Seniors: An interview Study** (includes both provider and policy/content expert interviews); and
4. **What Survey Data Tell Us**

Several themes are remarkably consistent across all five research arms and influence project recommendations:

- There are mismatches between what gets paid for and what's important to seniors;
- Today's payment policies create significant inefficiencies and harm Vermont's seniors;
- Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
- Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
- When possible care should go to patients rather than patients having to come to care;
- Control over health care budgets needs more community level influence;
- Primary care is in critical condition, and we all need to rethink how to support it;
- There are proven examples of how to do it better; and
- There is a lot that can be done right now!

Key findings from each of the four research reports are highlighted in the following paragraphs. The full text of the research studies themselves can be accessed on the project web site - <http://www.vmsfoundation.org/elders>

## **1. What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review**

<http://www.vmsfoundation.org/elders/matters>

For models of care that target frail and high-risk seniors to successfully deliver high-quality, high-value care, it is critical to understand seniors' perspectives on health and well-being and their perspectives on the health care and social service system. Understanding these perspectives at the onset makes it possible to choose and/or design a model of care aligned with what matters to seniors.

This study identified several factors important to seniors. Of these factors, maintaining independence was the most frequently cited response. Other factors that participants identified as important for their health, wellbeing, and quality of life included physical health, functional capacity, financial security, social connection to friends and family, being treated with dignity and respect, and reducing their burden on others.

*"To me I look at [good health] as being able to live a reasonably normal life. To be able to do some things that have to be done. To enjoy life as much as I can."*

*"Being able to be independent is the main thing. I don't like to rely on other people to do things for me. I want to be as independent as I can be. I've always made my own way in life and I want to do that as long as I can."*

The participants also identified several barriers to health care, including transportation, social isolation, caregiver burden, financial constraints, and limited availability of health care providers.

*"I can see the time where I am not going to be able to drive and that unnerves me and that makes me want to make sure there is transportation available."*

*"Pills are very expensive. Operations are very expensive. A lot of people are putting them off because they cannot afford to have them. I think that the whole medical system has to change. If you have plenty of money it doesn't matter, but if you don't people just don't go."*

Participant opinions were divided regarding their experiences with primary care. Many recalled very positive experiences of compassionate providers delivering individualized care. Others, however, described negative experiences with providers who lacked empathy. Multiple participants commented on the difficulty of recruiting and retaining primary care physicians in rural areas. Some participants suggested that the inability to speak with the primary care provider over the phone led to increased use of the emergency department. One suggestion that came out of the focus groups was that primary care offices provide more information about local health and social services.

*"[My PCP] has made it very easy to be who I am. You just feel better when you walk in the office. He represents health. In a wonderful way, you laugh. [My PCP was helpful] especially at times when I have had about of depression. . . . He was always there, and he helped me to embrace health."*

*“The doctor ... always made me feel ‘why are you here?’ I always felt that I was not sick enough to be there. I didn’t like that, and I was very aware of that.”*

*“You cannot get through to the doctors at Gifford. If you call, you get an answering machine. What kind of an answer is that when what you have is vital, but you do not need to use the ER services. You are forced to use those services. There is no other way.”*

Amongst participants who discussed emergency services, many described a lack of alternatives to the emergency department in rural areas, which led to inappropriate use of the emergency department. In general, participants felt that care in the emergency department was costly, impersonal, and not timely. Participant opinions were divided regarding hospital and specialist care at Gifford Medical Center and Dartmouth-Hitchcock Medical Center. Some appreciated the intimacy and personal nature of care at Gifford, whereas others preferred the more comprehensive services available at Dartmouth.

*“I also know that if I go to the [ED], they are going to do so much, and I don’t want any part of it.”*

Most of the participants had utilized local social and health care services. Participants universally praised the Central Vermont Council on Aging, but had mixed experiences with other services, such as Meals on Wheels and the Visiting Nurse Association. Satisfaction with home health services correlated with financial resources. Those who could afford private home health had a positive experience, whereas those with less financial resources expressed a need for additional subsidized home health services. Most participants were either reluctant to discuss the mental health system or did not have experience with it. One participant who had a positive experience receiving mental health services cited her relationship with her primary care provider as critical to enabling her to reach out for help and receive needed care. Many participants acknowledged the role of community organizations and volunteers as an important complement to the more traditional social service delivery system.

Lastly, participants were nearly universally enthusiastic about the concept of home visits from their primary care provider or a representative of the primary care office.

*“[Home visits]. That would be the dream!”*

The supporting literature review aligned with the viewpoints of the participants regarding factors that contribute to health, wellbeing, and quality of life, and barriers to care. The literature review also identified the following components of care as important to high-risk seniors: convenient access to providers, individualized and coordinated care, continuity of care, providers who listen well, and clear communication of a care plan.

## **2. Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review** <http://www.vmsfoundation.org/elders/atrisk>

As is well documented and frequently discussed in health care circles, there is a significant imbalance in health care spending in the United States. Over 50 percent of health care costs are incurred by only 5 percent of the population. This concentration of spending also exists within the senior population. Amongst seniors, there is a subset of individuals often termed frail or high-risk who face functional decline, decreased quality of life, and significant health care

spending. The frail and high-risk population has complex health and psychosocial needs. If these individuals are prospectively identified, their needs can be addressed through comprehensive models of care that lead to improved health outcomes and a reduction of health care utilization.

The literature review identified several overlapping characteristics for frail and high-risk seniors. These seniors have multiple chronic conditions, functional impairment, and poor self-rated health and quality of life. Multiple instruments are available to assess frailty and level of risk amongst seniors. However, unlike risk-assessment instruments, frailty assessment instruments were designed to evaluate current health and functional status, not to measure or predict health care utilization. In addition, risk assessment instruments more frequently include health care utilization history, demographic factors, and psychosocial factors.

Although feasible in theory, population-level screening through practitioner or patient-administered instruments is time-intensive and requires universal adoption by primary care providers. Predictive algorithms that utilize claims data, clinical data, or other available datasets to risk-stratify a patient population can be easier to implement at the population level, and in some cases they can more accurately predict poor outcomes (such as functional decline or hospitalization). For these analytic methods to most accurately predict risk, the datasets need to include data from multiple domains including diagnostic information, demographic information, functional status, and prior health care utilization. One approach to identifying high-risk seniors who could benefit from more comprehensive health care and services is to combine predictive algorithms with direct health and social service provider referral. This identification process should be followed by comprehensive in-person assessments of the highest-risk seniors to determine individual health and social needs.

#### What Models of Care Support Them?

The literature review identified several models of care targeting frail and high-risk seniors that led to improved outcomes. Two categories of models of care identified were Home-Based Primary Care (HBPC) and non-HBPC integrated care models. HBPC includes comprehensive assessments, individualized care plans, house calls by primary care teams, 24/7 availability by phone, mobile diagnostic technologies, coordinated subspecialty and mental health care, social services, and pharmacy services. Of note, HBPC has primarily been implemented in urban settings. The non-HBPC models identified in the review varied but components of these models included comprehensive assessments, individualized care plans, multidisciplinary team-based care, integration of social services and community resources, mental health services, self-management education, pharmacy services, and family member/caregiver support. Other approaches identified to support high-risk and frail seniors include community paramedics, community health workers, and care transition models.

Research has found that both HBPC models and non-HBPC integrated care models have improved patient satisfaction, decreased hospitalizations, decreased the number of skilled-nursing facility visits, and increased cost savings. Cost savings are generally achieved by

shifting spending from higher cost hospitalizations, emergency department visits, and skilled nursing facility stays to lower costs primary care and social services.

Payment reform is central to the success of these models of care. Payment reform that supports these models includes shared savings, capitated payments, and care management fees. Multi-payer reform can enable a broader pay base and greater financial support for these models of care. Workforce approaches, such as Community Health Workers and Community Paramedics, can be supported through reform that enables billing for services provided by these professionals.

### 3. **Caring for Seniors: An interview Study** <http://www.vmsfoundation.org/elders/caring>

Social determinants of health were universally identified by informants as critical factors in the well-being of seniors, particularly financial issues, social isolation, absence of a support system, living alone, and lack of transportation. Informants also cited medication issues, depression, and substance use as significant risk factors for seniors.

*"Social determinants play an even bigger role than the chronic medical conditions that we tend to focus on."*

*"People need a social convoy. Those who are connected with friends, family, and neighbors do so much better than those who are isolated."*

Although electronic medical records were seen as having some potential as a source for identifying at-risk seniors, primary care providers felt that there is no substitute for face-to-face interaction with their patients.

*"You have to lay eyes on the person to get the whole picture."*

Home visits were widely viewed as an excellent way for primary care providers to get a full picture of their senior patients' status, including both clinical and functional status and the critical social determinants of health and wellbeing.

*"If they don't come in [to the office], then it's too late and things are already happening. We're not sure why they're not coming in, if it's money or transportation or what. We've talked about how good it would be if nursing staff could go out to homes and do an assessment and also find out if people can make it to the office or does the doctor need to go to their home. But insurance doesn't pay for nurses to make home visits."*

The study found a number of systemic barriers to providing care and supporting seniors to achieve outcomes that matter to them. The most significant barriers fall into the categories of time constraints, reimbursement for home visits, Medicare limitations on home health agency services, inadequate access to home-based support services, and communication among providers.

*"You see it when someone's eligible for [home health] services. Nursing services are covered only for patients who are homebound and when there is a need for skilled care, but not for things like monitoring blood pressure, blood thinners, or fluid retention for patients with congestive heart failure. They get all kinds of services—nurses, physical therapy, occupational therapy, home aides. They do well for a few months, then they don't qualify and boom they go downhill and then boom it happens again. A lot of people fall through that gap where they don't qualify. Things fall apart, and the cycle repeats. There's no intermediate level of home care they can qualify for where they can get medication reconciliation or checks on their status. The more services they can get in the home, the better they're going to do. That would be so helpful for providers and patients."*

*"My one wish would be a sliding scale agency for home care, for aide-level care. That level of care is what most people need."*

*"It's hard to send information and wasteful to print and fax over and over when we could simply be coordinating if we all used the same EMR."*

Key informants identified aspects of their local delivery systems that are working well to support seniors in the domains of primary care, other health-related services, and community-based supportive services. They also identified services that are inadequate to meet seniors' needs. With the exception of access to primary care and mental health services and a difference in the care coordinator model in the two areas, the study generally found consistency in informants' reports about many aspects of the local delivery systems across the two PCSAs.

Care coordinators were viewed as key members of the primary care team, and informants expressed a strong preference for a model that has care coordinators based on site and fully integrated into the practice.

*"The care coordinator can fill the gaps for important things that inhibit care if they're not addressed but that the primary care provider doesn't have time or knowledge of resources to address. In some ways it's more important than what the primary care provider does. It certainly makes my job [as a PCP] more doable. It would be great to have them here more than once a week so I can hand people off right there at the time of the appointment. That works the best."*

Informants suggested care models and practice processes that would enhance the ability of primary care providers to care for seniors and potentially reduce cost. The study found particular interest in home-based primary care models as well as practice processes that use a team approach where primary care physicians are freed up to provide the care they are uniquely qualified to provide. The study also found interest in models that use other provider types, such as a community paramedicine and community health nurses, to reduce the burden on primary care practices.

Although not all informants expressed views on the topic of payment reform, those who responded showed consistent support for a move away from the current fee-for-service system and its encounter-based reimbursement model to a capitated system that aligns payment with quality and outcomes. Payment reform will also need to address numerous barriers to caring for seniors that are presented by Medicare policies regarding eligibility and reimbursement.

#### 4. What Survey Data Tell Us <http://www.vmsfoundation.org/elders/surveydata>

There are two surveys that can provide information in support of the Frail Elders project – the federal Medicare Current Beneficiary Survey (MCBS) and the Vermont Household Health Insurance Survey (VHHIS). Each of these can provide useful information but their value increases substantially if their information can be combined.

The MCBS is a national survey, containing a wide range of information on Medicare beneficiaries, including both utilization of medical services, health status, specific chronic diseases, and ADLs (activities of daily living). Because it is a national survey, too few Vermont residents are included to allow for any analysis of the Vermont population alone.

VHHIS is currently managed by the Vermont Department of Health. In the past, it has been managed by the Department of Financial Regulation. VHHIS is a large survey, designed to analyze health insurance coverage, socioeconomics, and knowledge of the health care system among Vermont families. While it provides excellent information in these areas, it does not include any health status information that would be useful to understand the needs of frail elders other than self-reported health status.

In order to provide information useful to this project, we explored the possibility of merging information from the two files. An example of a merger would be to apply the percentage of Medicare beneficiaries with Diabetes (from MCBS) to the number of Medicare beneficiaries aged 65 and over in Vermont (from VHHIS).

Prior to actually merging information, we looked at how comparable variables common to both surveys were. The table below shows a typical comparison. “Community” means MCBS information is limited to those who were not in long-term care for the year, which matches the scope of VHHIS (which does not include those living in institutions such as nursing homes).

Self-Reported Health Status	VHHIS	Community MCBS
Excellent	17.4%	15.9%
Very Good	31.8%	28.8%
Good	29.4%	29.6%
Fair	15.0%	18.0%
Poor	6.2%	7.7%
DK / UNK	0.3%	

As can be seen, there is good agreement between the two sources. The next step was to apply MCBS percentages to the Vermont Medicare population (example below).

Number of Chronic Conditions	MCBS Percent	Estimated VT Medicare
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None	5.4%	5,989
1-2	31.7%	35,160
3-4	39.1%	43,368
5 or More	23.8%	26,398
Total		110,916

As this analytic effort proceeds, additional information will be posted on the project website.

## Recommendations

Our recommendations are all founded on what we were told by seniors, by community based clinical practitioners and support service providers who aid their elders every day, by Vermont subject matter experts and from a review of published literature with the assistance of our University library system. The recommendations are our sincere attempt to design a care model that reflects what we were told or has been published in the peer reviewed literature. We anticipate and encourage serious discussion about our recommendations. We also encourage efforts to increase the breadth or depth of our research where needed. That being said, we hope that discussion and policy will not spin away from what seniors say matters to them and the knowledge of their caregivers who know them so well. Our recommendations are presented as answers to four core questions:

- 1. Who are our high-risk seniors?**
- 2. How will we measure success?**
- 3. How will we care for them?**
- 4. How will we pay for their care?**

### **1. Who are our high-risk seniors?**

The literature review found that frail and high-risk seniors are characterized by having multiple chronic conditions, functional impairment, impaired mobility, gait and balance problems, cognitive impairment, and depression. In addition, this subset of seniors frequently have high utilization of health care and social services and they are also more likely to be low-income, live alone, and have a lack of care giver availability.

The findings from the key informant interview study reflected similar characteristics for this population. Of note, key informants universally identified social determinants of health by as critical factors in the well-being of seniors, particularly financial issues, social isolation, absence of a support system, living alone, and lack of transportation. Informants also cited medication issues, depression, and substance use as significant risk factors for seniors.

Although electronic medical records were seen by key informants as having some potential as a source for identifying at-risk seniors, primary care providers felt that there is no substitute for face-to-face interaction with their patients. Home visits were widely viewed as an excellent way

for primary care providers to get a full picture of their senior patients' status, including both clinical and functional status and the critical social determinants of health and wellbeing.

A three-step identification process is recommended. Initially, existing data such as billing data and structured data in medical records for all patients known to a practice should be analyzed by a predictive algorithm; and patients risk stratified based on significant events, high utilization patterns, key diagnoses, social determinants of health and impairment in ADLs and IADLs if available. The resulting list of Identified patients should be reviewed for appropriateness by a dedicated practice senior care team. Subsequently practice team members can recommend additional patients known to them to be at risk of poor health outcome or a decline in the quality of their lives. All partner community support service providers are invited to recommend additional people in the community.

*"The people we're not catching are the people we don't see regularly."*

This identification process is based on the findings in the literature search and is consistent with what seniors, providers and subject matter experts said in their interviews. As with all the project recommendations, the reader is asked to consider the recommendation as an initial test of change. It will need to be monitored for success or failure in a continual cycle of improvement. The literature findings suggest that an initial test of change combine predictive algorithms with direct health and social service provider referral in order to identify high-risk seniors who could benefit from more comprehensive health care and supportive services. This identification process should be followed by comprehensive home-based medical and functional assessments of the highest-risk seniors to determine individual health and social needs.

Special mention must be made of the impact of failing functional status in terms of increasing risk to seniors for poor health outcomes and decline in the quality of their lives. Gauging functional status is complex and difficult. Changes in functional status are often gradual, nuanced and subtle. Change in functional status is rarely adequately documented in medical records. In-person assessment by a competent professional is extremely important and should be a core aspect of a comprehensive initial assessment and all periodic monitoring.

*"You really need to see people and have a conversation about their lives."*

*"Body language, eye contact, general hygiene—the whole slew of human interaction."*

For additional background on the suggested process, the reader is referred to the full study on this topic, **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review** <http://www.vmsfoundation.org/elders/atrisk>

## **2. How will we measure success?**

A multi-dimensional balanced evaluation is recommended. No single index of success is sufficient. Existing validated metrics should be used when possible and directly relevant to the process or system being evaluated. Annual ongoing comparisons to appropriate benchmarks

should be utilized rather than pre and post measures. The evaluation should include measures in the following domains:

- Social, clinical, mental health, substance use and the presence or absence of healthy behaviors (diet, exercise and tobacco use) as it relates to a person's ability to maintain or improve their health, e.g. PHQ9 screen for depression  
<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1>
- Functional measures including patient reported outcomes, e.g. activities of daily living (ADLs) and instrumental activities of daily living (IADLs), measures of patient goals being met and independence with sufficient self-management support, e.g. modified CAHPS  
<http://www.ahrq.gov/>
- Provider reported process and outcome measures including measures of access, provider satisfaction, number of patients meeting clinical goals, number of eligible patients and number of patients moved to a lower level (better) of care.
- Utilization and financial measures including hospitalizations, ED visits, long term nursing home placement and claims paid (both numbers of claims and dollar amounts as well as site of service). This data should be evaluated on the chosen cohort of patients for a minimum of two years prior to entry into the program and followed annually thereafter.

The clinical practices may have already developed measures for this population of patients that could be utilized to evaluate and monitor the population and this work should be considered.

For additional background on measurement, the reader is referred to the sections of how care models are evaluated in the literature search study **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**

<http://www.vmsfoundation.org/elders/atrisk>

### **3. How will we care for them?**

We propose redesigning care with the goal of providing healthcare when and where patients need it. The proposed redesign will support collaboration between healthcare and community services. Each senior in the high-risk group will have a comprehensive assessment by the practice's multidisciplinary Primary Care Team. Key members of the Team will be the primary medical practitioner, a practice nurse, the practice's integrated care coordinator and the patient and/or their caregiver. The comprehensive assessment will evaluate and consider clinical status, functional status, medical history, social history, knowledge of healthy behaviors (diet, exercise and tobacco use), mental health and substance use, social service needs, and long-term service and support needs.

The assessment will include a visit to the patient's home and a discussion of needed home-based services to support independence.

*"It always helps for someone to see the home environment, even it's not the doctor. You can order a safety evaluation from home health. But it would be good if someone from the practice could go in and see. You get all kinds of clues from seeing them at home that you don't get when they're in the clinic."*

Outside of the practice, but including the key representatives of the practice team, will be a Neighborhood Team. The Neighborhood Team will include representatives of appropriate community support and service providers with the patient and family's consent, such the Senior Center, Senior Meals, clergy, Support and Service at Home and the Area Agency on Aging. The patient and their caregivers are central members of both teams. The Neighborhood Team will support health and well-being in its broadest sense, addressing the seniors' need for socializing, exercise, food security, transportation, and access to state and community programs. The Neighborhood Team will meet with sufficient frequency to review new and emergency cases as well as periodic reviews of all high risk seniors in the community. Patients and families will always be able choose not to have their Care Plans discussed outside of the practice; their privacy concerns will be respected. The Practice Care Coordinator will be the principal contact between the Practice Team and appropriate community support providers represented on the Neighborhood Team.

The cohort of identified patients is given a special status in the practice, e.g. "The Gold Team" Identified hi-risk seniors will receive priority same-day appointments, home visits by PCP, office nurse and care coordinator, 24/7 access to phone assistance by someone who knows their special "Gold Team" status. We envision group medical visits for those who are able and comfortable with the format. Group visits may include community resource representatives as well as Practice Team members. Gold Team membership will hopefully promote a sense of having a special place in the practice and foster a sense of a community group. It may also raise community awareness of the program. These enhanced services are likely to decrease inappropriate calls to 911 and unnecessary hospitalizations

The Primary Care Team will work with seniors to develop their individualized Care Plan. Care Plans may include Advanced Directives and Vermont DNR/COLST form (a document that conveys patients' wishes for CPR, intubation, transfer to the hospital, antibiotics, artificial nutrition and hydration, as well as overall treatment goals).

Care Plans will include specific, personal and individualized information on life and health goals, such as, avoiding hospitalization, dying at home or making it to a granddaughter's wedding. They will include a list of people the patient and caregivers should feel free to call if needing help or not feeling well (to avoid getting sicker due to "not wanting to trouble anyone"), e.g. friend, family, visiting nurse and the name and contact information for their primary care practitioner. Care Plans will include personal goals, e.g. what the patient agree to work on, exercising or socializing for example.

The Primary Care and Neighborhood teams will work to support the Care Plans. Both teams will encourage as much home based care as possible, with visits from the practice team members and involved community support services. Patients should be encouraged to have their Care

Plans conveniently accessible to community care givers. All appropriate community service and clinical providers should have a copy with appropriate patient consent. Regular meetings including members from both teams will occur to review Care Plans in an effort to increase communication and ensure that all involved parties are aware of the patient's goals.

*"What we really need most is more basic support—aides, housekeepers, someone to help with bathing, dressing, socializing, shopping, shoveling the walk."*

The potential for creating a new community resource, community paramedicine, was mentioned in the provider interviews and identified in the literature search. Paramedicine is an evolving concept building on our current EMT system, in which specially trained EMTs provide home visits for some services, such as wound care and vital signs checks - "paramedicine programs aim to address critical problems in local delivery systems, such as insufficient primary and chronic care resources, overburdened EDs, and costly, fragmented emergency and urgent care networks". Despite growing enthusiasm for these programs, however, their performance has rarely been rigorously evaluated, and they raise important questions about training, oversight, care coordination, and value."<sup>1</sup>

Interviews with providers highlighted two related innovative programs building on the current EMS system in the two target PCSA's<sup>2</sup>. These Informants identified two programs that currently provide some home-based services to residents of some towns in the Gifford and Little Rivers PCSAs.

- Upper Valley Ambulance Service's Home-Sweet-Home Home-Safe Home program provides free home safety and injury prevention assessments. <http://www.uppervalleyambulance.com/site/services/home-sweet-home-home-safe-home/>
- First Branch Ambulance, through its grant-funded House Calls Program, does bandage changes and lab draws as well as blood pressure and glucose checks for patients who are unable to get to the clinic, follows up on ER visits, organizes medications, and does home safety assessments. <http://www.firstbranchambulance.com/house-calls.html>

Another recommendation from the provider interviews and the literature review is exploring the concept of community nurses (formerly known as parish nurses in the last century) as an additional community resource to complement the primary care team and be a member of the neighborhood team. Typically, community nurses are RNs who are based in the community and unaffiliated with a primary care practice. They are not care providers; rather, at no cost to patients, they can help patients to navigate the health care system, assess home safety, provide medication education and organization, and connect people to resources in their communities. Informants noted that there are community nurses in Thetford and Hartland, and preliminary conversations about feasibility have occurred in Bradford. Both community paramedicine and

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<sup>1</sup> Community Paramedicine n engl j med 374;12 nejm.org March 24, 2016 Community Paramedicine Community Paramedicine — Addressing Questions as Programs Expand Lisa I. Iezzoni, M.D., Stephen C. Dorner, M.Sc., and Toyin Ajayi, M.B., B.S.n engl j med 374;12 nejm.org March 24, 2016

<sup>2</sup> Caring for Seniors: An interview Study <http://www.vmsfoundation.org/elders/caring> pg. 19

community nursing are examples of redesigns that bring care to patients in the home, and could easily be included in the Primary Care Team model.

A third layer of community coordination are periodic meetings of representatives of both practice and community partners involved with staffing the Neighborhood Team to review and discuss the adequacy of the overall needs of the community's seniors and available local, state and federal resources. These meetings will serve as a basis for community advocacy on behalf of their seniors for redress of mismatches between community needs and available resources.

In summary, we propose practice redesign that stresses collaboration and communication between community and health care resources, places priority on the patients' own wishes, and increases capacity to deliver services to the patients when and where they need it.

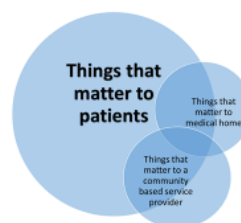
For the basis of the care model recommendations, the reader is referred to the interview study with direct care providers and subject matter experts **Caring for Seniors: An interview Study** <http://www.vmsfoundation.org/elders/caring> ; as well as the Care Models section of the literature search **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review** <http://www.vmsfoundation.org/elders/atrisk>

#### 4. How will we pay for their care?

While the design of a financing system must follow design of a delivery system, financing can have a strong effect on all aspects of system performance, including patient and provider satisfaction, quality of care, and value. We recommend that the payment model be focused first and foremost on addressing what matters to the patient. Evidence shows that what patients want is not always reflected in the current health care system. For example, a patient may rank staying in her home above her functional status.

#### VHCIP Frail Elders Project

##### Risk and Accountability?



It should recognize the risk of patients being cared for, in a more comprehensive way than current risk-adjustment methodologies do.

*"We just need more time" was a common refrain in the interviews. A physician summed it up this way: "The big issue is time. Mine, other providers, nurses. Whether it's my time to do home visits, then call the daughter, have thoughtful communications with a given patient. Or time for a home health nurse to dress a wound, cut toenails, be in the home, call the doctor, fill out a thousand pieces of paper. It's a system-wide issue. It's a huge barrier. If the system wants to avoid ER visits, avoid falls, hospitalizations, ideally primary care providers would have plenty of time to field phone calls, see patients acutely, do home visits, and see people before they get sick to cut down more costly services."*

It should hold the care organization accountable, but only for the outcomes that are within its control. One way of thinking about risk in health care is to divide it into three types – patient choices, provider choices, and the unpredictable (“insurance risk”). While the care organizations that would develop under this model should be accountable for the consequences of its own choices, they should not be held accountable for the actual cost of major health events that would be expected in a typical group of high-risk elders. However, ways should be explored to identify and reward reductions in the rate of those events below expected.

It should permit the use and coordination of a broad range of services, both medical and social. There is an increasing body of evidence that appropriate use of social services can reduce the need for higher-cost medical interventions.

*"We need to refocus on keeping people well through payment reform, and change metrics and dynamics so dollars can be spent on transportation, the elder care [mental health] clinician program, senior meals. Focus on social determinants of health rather than within the walls of the hospital. This is smart health care spending."*

Several funding mechanisms are in operation in the US and Canada that support parts of the recommended care model. None of them support all the components of the recommended model nor do many of them cast a wide enough net to capture all the high risk seniors in our rural communities. Two programs are presented below to highlight key issues: 1) The Commonwealth Health Alliance’s Senior Options Program; and, 2) the CMS demonstration project, Independence at Home. We are highlighting these two programs because they are in operation presently, demonstrate remarkable success in delivering care in a manner that matters to seniors and illustrate the potential for innovative care models and payment policy. The reader should be cautioned that eligibility for both these programs is directed at seniors with either the most limited financial resources or a very high need of clinical care. If these programs were to be implemented as is in the two target Vermont communities, many seniors would be left out. However, elements of both these programs, if adapted to address the needs of Vermont’s high-risk seniors, would be an improvement over the status quo.

### **The Commonwealth Care Alliance Senior Options Program**

<http://commonwealthcaresco.org/>

Traditional Medicare FFS part B does not have the flexibility of payment methodologies to support our recommended care model. However, alternative payment models exist that provide this flexibility. One example is a Medicare Advantage Special Needs Plan. This program allows a private company to contract with Medicare and then provide all Part A and B benefits to its members as well as enhanced benefits such as vision and dental services. In the case of Special Needs Plans they may limit membership to those with specific chronic and disabling conditions such as heart failure and diabetes. The specific list of conditions covered is likely to encompass all at-risk elders and allow eligibility. The plan can provide coverage for all services within the recommended care model in addition to other services such as care coordination.

*"If they don't come in [to the office], then it's too late and things are already happening. We're not sure why they're not coming in, if it's money or transportation or what. We've talked about how good it would be if nursing staff could go out to homes and do an assessment and also find out if people can make it to*

*the office or does the doctor need to go to their home. But insurance doesn't pay for nurses to make home visits."*

The Commonwealth Care Alliance Senior Options Program is a coordinated care plan which is a successful example of a Medicare Advantage Special Needs Plan. The plan provides many of the aspects of the recommended care model as part of their routine care. In addition members receive vision and dental coverage (including dentures), person to person comprehensive medication reviews with a pharmacist, coverage for home health services and also health related services such as personal care attendant services and homemaker/chore services. The plan has been in existence for many years and is highly rated by the Medicare quality rating system (4.5 out of 5 stars).

### **The Independence at Home Project**

<https://innovation.cms.gov/initiatives/independence-at-home/>

The Independence at Home demonstration is a project of the CMS Innovation Center and currently has 14 participating sites in the United States. The project supports the delivery of comprehensive primary care services at home for Medicare beneficiaries with multiple chronic conditions. Practices were measured on multiple quality measures and if they exceeded minimum quality thresholds were eligible for shared savings through the payment model. The practices had to have experience caring for patients with multiple chronic conditions and serve at least 200 eligible beneficiaries. The primary care teams also include physician assistants, pharmacists, social workers, and other staff.

The CMS analysis found that Independence at Home participants saved over \$25 million in the demonstration's first performance year – an average of \$3,070 per participating beneficiary – while delivering high quality patient care in the home. Patients who participated in the project had on average:

- Fewer hospital readmissions within 30 days;
- Follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency department visit;
- Have their medications identified by their provider within 48 hours of discharge from the hospital;
- Have their preferences documented by their provider; and
- Use inpatient hospital and emergency department services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection.

The total shared savings practices received at the end of year one of the project as of June 2015 were \$11,668,023.

One step further might be a monthly bundled risk adjusted population health payment for this subset of patients with incentive based on outcomes important to patients within a larger all payer model system as might be conceived in Vermont in the near future. This model would be unique to Vermont as part of the larger Medicare waiver program and administered by the accountable care organizations.



The paramount issue about payment is that a payment methodology should be the last question to be addressed. What matters to seniors as presented in the project findings needs to always be of primary importance and the final guide to any decisions about care model design, measures of success and funding mechanisms to support care.

For additional background on payment of innovative care models for seniors, the reader is referred to the sections on care models in the literature search study- **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**

<http://www.vmsfoundation.org/elders/atrisk>

## Conclusions

The Project Recommendations are all based on what Vermonters told the Research Team or can be found in the existing peer reviewed literature. These Vermont voices are rural seniors and their caregivers, rural community medical and support service providers and Vermont content experts.

The Findings of the Project capture what was shared and learned. The Project Findings are at least as important as the Recommendations in that they collectively offer a set of very defensible goals for health care reform and expansion of support services in our rural communities. Nine themes are consistent across the Research arms:

1. There are mismatches between what gets paid for and what's important to seniors;
2. Today's payment policies create significant inefficiencies and harm Vermont's seniors;
3. Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
4. Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
5. When possible, care should go to patients rather than patients having to come to care;
6. Control over health care budgets needs more community level influence;
7. Primary care is in critical condition, and we all need to rethink how to support it;
8. There are proven examples of how to do it better; and
9. There is a lot that can be done right now!

The Research Team took care to be as objective as possible in promulgating the Recommendations. That being the case, some subjectivity is unavoidable. The Recommendations represent our sincere effort to make practical suggestions to improve the care of the seniors in at least the two targeted rural communities. Adding to the credibility of the recommendations is that the membership of the Team includes three primary care physicians who practiced in both the target communities for many years.

There is no existing system of care exactly like the proposed model; however, every component exists elsewhere, and most have been rigorously evaluated by independent qualified experts.

Taken together, our recommendations outline a new model of care that is driven by the priorities identified by the seniors in our communities; and can be expanded to other special populations of Vermonters and other community based primary care settings.

The Recommendations are also offered with the hope that, if implemented, some of the stress on our rural primary care practices will be eased through increased practice efficiencies, replacing current documentation requirements with more meaningful and transparent measurement and increasing professional satisfaction and joy in the workplace.

Since the initial discussions in 2012 that evolved into the Frail Elders Project, the underlying impetus for the effort has always been to improve the primary care delivery system in Vermont. The project team chose to focus on frail and high-risk seniors knowing: 1) care could be better; 2) improvements could potentially effect multiple practice and community services; and 3) recommendations could be generalized to other patients and communities. All those who have been part of the effort have hoped for broad impact. They want to foster a rethinking of primary care. They wanted to create a reform paradigm in which payment innovation serves practice innovation, with things that matter to patients as the paramount driver of reform. And with the hope of taking a small step towards setting right what's wrong with primary care in the State.