Patient-Centered Medical Home (PCMH) and the Care of Older Adults

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More than 50% of older adults have multiple chronic conditions, with distinctive cumulative effects for each individual [1, 2]. As an older adult's number of chronic conditions accumulate, the risk of dying prematurely, hospitalization, functional decline, and health-care costs increases [3]. Addressing complex medical care is most effective when it is comprehensive, patient centered, and coordinated by a team of trained health-care professionals that is accessible in primary care settings where most older adults receive treatment [4].

The patient-centered medical home (PCMH) is a promising model for transforming the organization and delivery of comprehensive, cost-effective primary care. Originally introduced by the American Academy of Pediatrics (AAP) in 1967, the medical home concept initially referred to a central location for archiving patient's medical record. In 2002, the AAP expanded the medical home concept as a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective to every child and adolescent. The PCMH concept was adapted to patients of all ages by the American Academy of Family Physicians (AAFP) in 2004 and by the American College of Physicians (ACP) in 2006. It served as a transition away from historically episodic care toward a framework of comprehensive coordinated primary care for patients of all ages. In 2007, the AAP, AAFP, ACP, and the American Osteopathic Association developed a joint statement of principles to describe the characteristics of the PCMH and to lead changes at the physician practice level to improve outcomes in today's primary care practices [5].

Since then, the PCMH model has evolved to improve population health outcomes, enhance the patient experience, reduce per capita health-care spending, and support care team well-being through team-based coordinated care. According to

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the Agency for Healthcare Research and Quality (AHRQ), the PCMH encompasses five major functions and attributes: comprehensive care, patient centered, coordinated care, accessible services, and quality and safety [6]. The PCMH model of care has the potential to improve the health of older Americans, as it is uniquely aligned with the values of geriatric medicine to deliver primary care for high-cost, high-need older adults with complex health needs [7, 8]. This chapter reviews considerations for the aging population and components of PCMH highlighting that interprofessional care of older adults is oriented to the whole person, coordinated, and comprehensive, with an emphasis on patient safety and quality of care.

Comprehensive care is a vital function of the PCMH and refers to a team of health-care providers accountable for addressing the majority of a patient's physical, mental, and behavioral health-care needs, including prevention and wellness, acute care, and chronic care. The PCMH advocates for a personal physician who is informed by an interdisciplinary team, which may include consulting physicians, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators, to meet the complex needs of patients with multiple comorbidities and increasing frailty and disability [9]. A core principle of geriatric medicine has been the use of interprofessional team-based care of older adults and application of comprehensive geriatric assessment to address health needs systematically and to provide age-appropriate preventive care consistent with the older adult's goals of care. Successful model of a geriatrician-led team that actively coordinates care and provides comprehensive care across disciplines has been the Department of Veterans Affairs (VA) home-based primary care (HBPC) [10]. Established in 1972, the HBPC has been expanded across VA facilities in the country to provide comprehensive, cost-effective, longitudinal primary care by an interdisciplinary team to homebound aging veterans with multiple chronic and disabling conditions [11]. The comprehensive care approach becomes more evident for older adults who experience medical and social challenges and transition through various care settings and services [12]. Geriatricians are trained to work as part of a team of health-care providers to care for older adults with complex health needs, as they are likely to experience physical and social inactivity, falls, functional decline, polypharmacy, barriers to adequate nutrition and transportation, depression and memory problems, and potential for elder abuse [13]. Geriatric medicine aligned with the PCMH model can account for these special considerations when developing comprehensive care plans for older adults.

Patient-centered care, or care that is oriented toward the whole person, is another function of the PCMH, which calls for a physician-led, team-based health-care model that focuses on building partnerships with patients and families through an understanding of and respect for culture, needs, preferences, and values. The PCMH model actively supports older adults in learning to manage and organize their own care at the level they choose, as an individual's daily life may involve various caregivers, access to independent or assisted living, management of multiple chronic conditions, and the need for advance care planning prior to functional decline [14]. Caring for older adults requires clinicians who are sensitive to whole-person care across a lifespan taking account of advance care planning for serious illness and

end-of-life care and social determinants of health. Recognizing that patients and families are core members of the care team, the PCMH model focused on older adults can ensure that they are fully informed partners in establishing their own care plans [15].

Coordinated care entails the integration, management, and organization of patient care and services across various health-care systems including specialty care, hospitals, home health care, long-term care, and community services, with an emphasis on efficient and safe transitions of care. The team-based approach to care in geriatric medicine is central in assisting older adults to navigate the continuum and complexity of the health-care system to prevent them from falling through gaps in care [16]. Similarly, the PCMH model promotes care coordination to improve communication between organizations and specialists, leverages health information exchange, and facilitates follow-up with primary care providers that may reduce avoidable readmissions and improve health outcomes especially for those with complex care needs [17]. Physicians can lead teams caring for older adults to identify high-need, high-cost patients and develop individualized, coordinated plans of care that integrate medical and social issues. Based on demonstrations of various PCMH models, care coordination enables teams to address problems comprehensively and deliver age-appropriate preventive care [18]. Founded in 1978, the Programs of All-Inclusive Care for the Elderly (PACE) emerged as a successful managed-care program that coordinated comprehensive medical care and long-term services and support to frail, nursing home eligible patients to live independently in the community and with a high quality of life. Based on a recent retrospective study, PACE enrollees experienced lower rates of hospitalization, readmission, and potentially avoidable hospitalization than similar populations [19]. Older adults with multimorbidity benefit from care coordination and multidisciplinary team-based care as their health-care needs may become complex to be addressed effectively by independent primary care providers.

The PCMH framework delivers accessible services with reduced wait times for urgent care needs, enhanced and flexible office hours, and 24/7 telephone or electronic access to primary care physicians (PCPs), and alternative methods of communication through health information technology. Increasing support to PCPs with enhanced access can reduce emergency room visits and unmet health-care needs [20]. Providing accessible services is essential for caring for older adults who may lack personalized care and needs in the home and lack social support or advocacy assistance, and office visits may place a burden on patients and caregivers. The PCMH model can provide support and guidance to older adults with self-management of multiple chronic conditions and caregiver support. Extended visits in the office setting can accommodate community-dwelling older adults with physical and mental limitations.

The PCMH model is committed to continuous quality improvement and patient safety strategies through clinical decision support tools, information technology, evidence-based care, shared decision-making, performance measurement, and population health management. Measuring medical care for older patients is complex and has to account for multimorbidity, geriatric syndromes, and social issues that

contribute to variations in care preferences and planning. The Assessing Care of Vulnerable Elders (ACOVE) indicators aim to evaluate the range of health-care problems experienced by vulnerable older adults in the community who are at increased risk of functional decline [21]. States and commercial payers have piloted various forms of payment alignment to support primary care, and the PCMH generally demonstrated better quality of care, patient experiences, care coordination, and access [22]. For instance, the Geriatric Resources for Assessment and Care of Elders (GRACE) model of primary care for low-income seniors and their PCPs has been demonstrated to improve the quality of geriatric care and optimize health and functional status of older adults. The GRACE support team meets with the patient in the home to conduct an initial comprehensive geriatric assessment and then meets with the larger GRACE interdisciplinary team to develop a comprehensive, patient-centered care plan in collaboration with the patient's PCP that is consistent with the patient's goals and preferences of care. The effectiveness of the GRACE intervention has shown decreased use of the emergency department and hospitalization rates of high-risk older patients and has prevented long-term nursing home placement [23]. As such, the PCMH presents an ideal opportunity to use quality indicators and metrics toward primary care of older adults.

The PCMH has been an effective model for addressing the diverse medical and complex care needs and transforming how primary care is organized and delivered in a sustainable manner for our health-care system and stakeholders. A new paper released by The John A. Hartford Foundation PCMH Change AGEnts Network offers recommendations on how PCPs can improve health outcomes for older adults through geriatric PCMHs and succeed in the emerging value-based payment health-care environment [24]. As discussed in the concept paper, PCPs can begin to transform their existing practices and workforce to address the particular concerns of older adults. PCMH steps to serve older adults include the use of the Medicare Annual Wellness Visit to create a patient-centered care plan. As PCPs cannot address all of the needs of older adults alone, they can collaborate with community organizations, such as Area Agencies on Aging, which provide services and support to older adults and their families and caregivers to become better self-managers of their care. Moreover, advance care planning conversations can help identify and update goals of care according to patient's wishes over time. As such, PCPs can facilitate better transitions of care by leading and monitoring relationships with specialists, local hospitals, and long-term care settings. Lastly, PCPs can provide training and education of all staff to deliver geriatric-competent care. A PCMH enhanced for older adults can enable PCPs to provide better care for the population they already serve.

Given the demographic imperative of an aging society, the PCMH enhanced for older adults is an ideal model to strengthen the care of all populations, as primary care becomes the focal point of complex care coordination. It has demonstrated improvement in patient care with respect to transitions of care, access to care, patient and caregiver education, chronic disease self-management, decreased hospitalizations and emergency room visits, and decreased health-care costs. The PCMH

model can mature and expand to identify and address the growing, complex medical and psychosocial needs of older adults. Moving forward, geriatric medicine principles and experience of care models for older adults add to the growing national attention to patient-centered quality care and improve clinical outcomes pursued by primary care clinicians across the country.

References

1. Chronic Disease Prevention and Health Promotion. https://www.hhs.gov/ash/about-ash/multiple-chronic-conditions/index.html.
2. Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No. Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; April 2014.
3. CDC Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm.
4. American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Patient-Centered Care for Older Adults with Multiple Chronic Conditions: a stepwise approach from the American Geriatrics Society.
5. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. 2007. http://www.medicalhomeinfo.org/downloads/pdfs/JointStatement.pdf.
6. Defining the PCMH. https://www.pcmh.ahrq.gov/page/defining-pcmh.
7. Langston C, Undem T, Dorr D. Transforming primary care what Medicare beneficiaries want and need from patient-centered medical homes to improve health and lower costs. 2014. http://www.johnahartford.org/blog/view/policy-briefing-transforming-primary-care-what-medicare-beneficiarieswant.
8. Centers for Medicare and Medicaid Services. Chronic conditions among Medicare beneficiaries, chartbook. 2012th ed. Baltimore, MD; 2012.
9. Ensuring that patient-centered medical homes effectively serve patients with complex health needs. https://www.pcmh.ahrq.gov/page/ensuring-patient-centered-medical-homes-effectively-serve-patients-complex-health-needs.
10. Beales JL, et al. Veteran's affairs home based primary care. Clin Geriatr Med. 25(1):149–54.
11. Edes T, Kinosian B, Vuckovic NH, Olivia Nichols L, Mary Becker M, Hossain M. Better access, quality, and cost for clinically complex veterans with home-based primary care. J Am Geriatr Soc. 2014;62:1954–61. doi:10.1111/jgs.13030.
12. Transitions of care: the need for a more effective approach to continuing patient care. https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf.
13. What is a geriatrician? American Geriatrics Society and Association of Directors of geriatric academic programs end-of-training entrustable professional activities for geriatric medicine. http://onlinelibrary.wiley.com/doi/10.1111/jgs.12825/full.
14. Lipson D, Rich E, Libersky J, Parchman M. Ensuring that patient-centered medical homes effectively serve patients with complex health needs. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO 2.) AHRQ Publication No. 11. Rockville, MD: Agency for Healthcare Research and Quality; October 2011.
15. Peikes D, Genevro J, Scholle SH, Torda P. The patient-centered medical home: strategies to put patients at the Center of Primary Care. AHRQ Publication No. 11-0029. Rockville, MD: Agency for Healthcare Research and Quality; February 2011.
16. Partnership for Health in Aging Workgroup on Interdisciplinary Team Training in Geriatrics. Position statement on interdisciplinary team training in geriatrics: an essential component of quality health care for older adults.

17. Rich E, Lipson D, Libersky J, Parchman M. Coordinating care for adults with complex care needs in the patient-centered medical home: challenges and solutions. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I/HHSA29032005T). AHRQ Publication No. 12-0010-EF. Rockville, MD: Agency for Healthcare Research and Quality; January 2012.
18. Patient-Centered Primary Care Collaborative. The outcomes of implementing patient-centered medical home interventions: a review of the evidence on quality, access and costs from recent prospective evaluation studies, August 2009.
19. Segelman M, et al. Hospitalizations in the program of all-inclusive care for the elderly. J Am Geriatr Soc. 2014;62:320–4.
20. Benefits of implementing the primary care medical home: a review of cost & quality results, 2012. https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home.
21. Assessing Care of Vulnerable Elders (ACOVE). http://www.rand.org/health/projects/acove.html.
22. The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence, 2014–2015. https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015.
23. Counsell SR, Callahan CM, Buttar AB, Clark DO, Frank KI. Geriatric resources for assessment and care of elders (GRACE): a new model of primary care for low-income seniors. J Am Geriatr Soc. 2006;54:1136–41. doi:10.1111/j.1532-5415.2006.00791.x.
24. Patient-centered medical homes and the care of older adults: how comprehensive care coordination, community connections, and person-directed care can make a difference. http://www.johnahartford.org/newsroom/view/patient-centered-medical-homes-and-the-care-of-older-adults-new-paper-provi.