Improving the Care of Older Adults through Patient-Centered Medical Homes

A Guide to Special Considerations for an Aging Population

Patient-Centered Medical Homes (PCMH) are a powerful driver for transforming primary care, but too often they miss opportunities to provide quality care to the growing high-cost, high-need population they serve—older adults with complex health concerns.

It's no secret that there are barriers, challenges, and gaps in the current care approach to older adults. In this brief, we provide a quick reference guide that addresses the special considerations for an aging population—and the challenges and opportunities for improving treatment—in the areas of comprehensive care, whole-person care, patient empowerment and support, care coordination and communication, and access to care.

"This guide will help PCMHs focus on their older patients, achieve their goals of providing great patient care for their most vulnerable populations, and succeed in the emerging value-based payment health care environment."

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Special Considerations for an Aging Population, Challenges, and Opportunities

COMPREHENSIVE CARE		
Special Considerations for an Aging Population	**Challenges**	**Opportunities, First Steps**
Mental and behavioral health	Depression, grief, loss, addiction, mental illness, social isolation, lack of community support	Opportunity to link older adults to community resources and specialty providers that will help
Cognitive changes	Cognitive impairment, dementia, caregiver burden, planning for care and long-term services and supports	Opportunity to assess person-specific goals and strategies to meet changing needs, link older adults and caregivers to community resources
Multiple chronic conditions, increasing frailty, disability	Fall prevention, incontinence, arthritis, cardiac disease, lung disease, etc.	Primary care management and patient advocacy while coordinating specialty care with a focus on patient's goals
Health care conflated with concerns and needs around daily life; housing, finances, transportation, social isolation and other non-medical issues	Meeting essential needs while managing health care–specific needs	Awareness of and access to community-based long-term services and supports; provision of care navigation and care management
Advance care planning for serious illness and end-of-life care	Complicated issues around advance directives, palliative care, hospice, Physician Orders for Life-Sustaining Treatment	Discussion of advance directives for conscious dying; initiating the discussion
Social support and other services needed and lack of access	Lack of awareness of/connection to what Area Agencies on Aging can support, which includes: ■ *Home-delivered/congregate meals* ■ *Transportation* ■ *Medication review* ■ *Respite/caregiver support* ■ *Falls/home risk assessments* ■ *Information and assistance* ■ *Personal care* ■ *Employment-related supports* ■ *Housing* ■ *Homemaker* ■ *Shopping* ■ *Money management*	Integration of area Agencies on Aging, Aging and Disability Resource Centers, independent living centers, community-based organizations, senior centers, etc. to be involved in helping access these services

"Given the changing demographics of the United States, most PCMHs are already providing care for an aging panel of patients. Rather than completely changing the PCP to serve older adults, this paper proposes layering in systems that will serve older adults and ultimately benefit the entire population of patients."

WHOLE-PERSON CARE

Special Considerations for an Aging Population	Challenges	Opportunities, First Steps
Personal preferences and values are factored into the care plan and all care is aligned with patient preferences and goals	Eliciting and recording care plans that are built upon patient's goals for the electronic health record	Opportunity to redesign care plans so that personal preferences are honored
Defining outcomes that matter	Quality measures for the whole population may not match an individual's goals and preferences	Tie quality measures to functionality, quality of life, life satisfaction, activation, and/or health confidence; tie quality measures to activities of daily living/ instrumental activities of daily living and life activities that have special meaning (i.e., interaction with grandchildren, gardening, etc.)
Inclusion of family and caregivers	Seventy percent of long-term care is provided by family and informal caregivers; caregivers may also be burdened by the volume of need	Opportunity to invite family and caregivers as active participants in the care team and need to be factored in, physically and electronically

PATIENT EMPOWERMENT AND SUPPORT

Special Considerations for an Aging Population	Challenges	Opportunities, First Steps
Self-management tools and services (Note: Patient-centered medical home certification by National Committee for Quality Assurance [NCQA, n.d.a] has a requirement for patient self-management)	Difficulty in self-management for older adults, caregivers, and families; patients and caregivers have very little formal education and knowledge on how to manage diseases or conditions	Condition-specific self-management tools; after-visit summaries; prevention reminders; evidence-based chronic disease self-management, both online and in person (Stanford Patient Education Research Center, 2016)
Shared decision-making tools	Complexity in decisions for older adults; culturally appropriate approaches to care; health literacy	Preference-sensitive care; informed choice/informed consent; consider translators, language preference, and health activation status
Alternative ways to engage in care, including: personal physician, personal health coach, group appointments, support groups	Expanding access	Addressing the need for older patients to have continuity of connection with care team; create a sense of "home" in the patient-centered medical home
Patient-generated data	Eliciting opinions and preferences for older adults' care plans; finding time to elicit goals; computer access and literacy	Conducting care experience surveys; symptom assessments; patient-generated data in the electronic health record for pre-visits; making changes to care goals; responses to shared decision-making tools; integrating data to improve care

CARE COORDINATION AND COMMUNICATION

Special Considerations for an Aging Population	Challenges	Opportunities, First Steps
Prescription medication management	Primary care coordination	De-prescribing unnecessary or harmful medications; opportunity to understand patient "nonadherence"
Care across settings: home, clinic, hospital, nursing home, hospice	Complex patients with complex needs; keeping patients and family informed	Primary care coordination and patient advocacy across all settings; caregiver involvement; planning with use of care plan
Specialty care management; proactive care transitions	Complex patients with complex needs; keeping patients and family informed	Primary care coordination and patient advocacy across specialty care encounters; patient can view notes in the electronic health record and provide feedback through OpenNotes

READY ACCESS TO CARE

Special Considerations for an Aging Population	Challenges	Opportunities, First Steps
Home visits and home assessments	Lack of personalized care and needs in the home; lack of social supports, including transportation and meal preparation	Occupational therapy and safety assessments; home-monitoring devices; home-based primary care; Hospital at Home; home-based palliative and hospice care; caregiver support and training
Health coaches	Lack of support and advocacy assistance	Available by phone, in home, or at the clinic to provide support and guidance for chronic condition self-management, caregiver support, etc.
Patient-facing and patient-friendly health information technology	Access to medical records and information at all times; use of plain language in medical information	Availability/accessibility of medical information
Flexibility in visit design	Many office visits placing a burden on older adults and caregivers	Extended visits to accommodate physical/mental limitations and caregiver support; group visits; e-visits; and telemedicine

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In it you'll find compelling stories of PCMH successes, examples of how practices are implementing evidence-based models of care, recommendations on engaging community-based organizations, guidance for operating within MACRA and APMs without risk of financial loss, ideas for enhancing primary care delivery, links to resources to aid PCMHs in addressing workforce issues, ensuring patient safety, and more.

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