Patient-Centered Medical Homes and the Care of Older Adults

How comprehensive care coordination, community connections, and person-directed care can make a difference

Achieving success as a PCMH is a journey. In order to succeed, PCMHs must address the unique needs of what is often a growing and costly group of the patients they serve—older adults. This new and practical publication offers a roadmap to meeting the challenges PCMHs face, including:

• How practices can improve outcomes by implementing evidence-based models of care and enhancing primary care delivery, particularly in the areas of comprehensive care, whole-person care, patient empowerment and support, care coordination and communication, and ready access to care;

• How community-based organizations can play an integral role in helping PCMHs maintain older adults’ independence and quality of life;

• How advanced PCMHs can benefit under the Medicare Access and CHIP Reauthorization Act (MACRA) and employ Advanced Alternative Payment Models (APMs) without putting themselves at risk of financial loss;

• Links to resources to aid PCMHs in addressing workforce issues, partnering with community-based organizations, accessing clinical assessment tools, ensuring patient safety; and

• Compelling stories of how PCMHs have transformed outcomes for older adults.

PCMH Steps to Better Serve Older Adults

1. Use the Medicare Annual Wellness Visit to create a patient-centered care plan.

2. Partner with community organizations, such as Area Agencies on Aging, that provide services and support to older adults and their families and caregivers and fill gaps in care.

3. Initiate advance care planning conversations to identify goals of care, and update as patients’ wishes change over time.

4. Facilitate better transitions of care by establishing and monitoring relationships with specialty care, local hospitals, and long-term care settings.

5. Provide training and education of all staff to provide geriatric-competent care.

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