



Patient-Centered Medical Homes and the Care of Older Adults

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

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THE PROBLEM

The population of the United States is aging; aging comes with a unique set of ongoing health care and social needs. To meet these needs and achieve Triple Aim outcomes, our health system must adapt to become more comprehensive, coordinated, continuous, and effective in the context of an aging population. Reform efforts, such as the patient-centered medical home (PCMH) model, are a promising template for better primary care. However, national and local definitions of PCMHs have little or no focus on geriatric expertise, including advance care planning, functional status, or comprehensive assessments and interventions for older or medically complex patients and their caregivers. In addition, the focus on individuals' goals is oftentimes not elicited and/or communicated among providers of care. If PCMHs are going to succeed in their goals of improving patient outcomes and lowering costs, they must address the unique needs of older adults.

Vision of The John A. Hartford Foundation (JAHF) Patient-Centered Medical Home Change AGENTS Network

The JAHF PCMH Change AGENTS Network will transform Patient-Centered Medical Homes to recognize, facilitate, encourage, and ultimately reward providing the right kind of care for older adults and their caregivers based on their values and goals. We also propose to enhance PCMHs' connection to relevant resources, including family caregivers and community-based organizations that will allow individuals with complex needs to live with the dignity and independence they want to have, with health care needs met reliably and well, and with a sense of well-being and inclusion in personal relationships and in the community—and with sustainable costs for families and society at large.

It is the goal of the JAHF PCMH Change AGENTS Network to support the overall success of PCMHs through better policy and implementation by reframing the PCMH model to establish the value of caring for older adults and defining a set of PCMH standards that increase the likelihood of better outcomes for older adults. In order to meet these objectives, Network team members will collaborate to distill our ideas into measurable, actionable, and timely goals. The Network will also seek input from other Hartford Foundation initiatives and geriatrics experts in health care. This concept paper seeks to outline the principles of PCMHs in a geriatric-focused context and offer recommendations to make it easier for primary care physicians to address the needs of older adults.

The JAHF's mission is to improve care of older adults and its Change AGENTS Initiative is supporting the PCMH Network to help advance multidisciplinary practice change and innovation. Visit changeagents365.org to learn more.



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Introduction: A Patient-Centered Medical Home Success Story

A patient-centered medical home (PCMH) can have great success in supporting and treating older adults. When all the threads of accessible, comprehensive, safe, quality, and coordinated care come together, a PCMH can help even an octogenarian recover from a setback, as illustrated by the real-life case of an older adult, Hilde. Hilde's care shows that treating older adults and maintaining quality of life are important and possible when coordinated through a PCMH.

Hilde is an 89-year-old retired high school teacher. She walked two miles a day and had been an active community volunteer for her church since her husband passed away two years ago. She had increasing caregiver responsibilities as he had struggled with Alzheimer's disease for more than ten years.

Hilde had diabetes mellitus and hypertension, which she managed well on her own with a yearly check in with her primary care physician (PCP) or nurse. Everyone remarked how well she was doing at 89 years of age; her family couldn't imagine her in any other role than "mom," taking care of kids and grandkids alike.

One night, rushing to the bathroom, she fell and broke her dominant right wrist. It was a severe fracture that required surgical repair and casting for three months. Because it was so difficult to do some activities of daily life, she went to her oldest daughter's home after surgery. She relocated about 30 minutes away from her own home, which effectively removed her from all her usual activities and friends. She became afraid of falling and stopped walking. Some family members thought she should consider moving into a retirement community nearby.

While Hilde continued to manage her diabetes mellitus and hypertension, she became increasingly depressed and isolated. She felt like a burden on her family for the first time in her life. At her ten-day follow-up visit with her PCP at the PCMH, her team became alarmed. She had transformed from an independent, “amazing” woman into one showing signs of depression.

A physical therapy evaluation was scheduled for overall conditioning to prevent further decline, and a PCMH team member called regularly to check on Hilde. But, the longer she stayed with her daughter, the more depressed she became. After one month, she reported little pleasure in activities and was often feeling sad and blue. She worried about her memory and became very concerned that she was developing Alzheimer’s disease as her husband had. She did not want to be a further burden to her children, but she knew her financial resources had been depleted by her husband’s long illness and long-term care needs. Would there be anything left for her to support herself?

Hilde’s PCP knew from the orthopedist that her wrist was healing well and her chronic conditions were under good control. Depression, memory concerns, and lack of physical and social activity had become the functional issues threatening her quality of life, which if left unaddressed, could have led to a cascade of decline with emergency department visits, hospitalizations, and even possible nursing home admission. Addressing her needs and goals has the potential to prevent other unwanted and costly care.

The PCP discussed her overall care with the medical assistant (MA) and registered nurse (RN) regularly, and clearly documented Hilde’s wishes and goals for her life in the electronic health record (EHR). The team social worker further assessed for depression and followed up with regular counseling. The social worker made connections to community-based organizations (CBOs) that offered services that could allow Hilde to return to her home safely if she desired. Hilde was able to see that independent living might still be a choice for her, and her depression resolved. Full cognitive testing was negative for significant memory problems, which greatly relieved her concerns.

Within two months, Hilde had put enough supports in place to return to her own home safely with the help of CBOs. Within three months, she was able to

return to all her usual activities. She became more confident in her ability to remain in control through her remaining years.

Hilde’s plan of care documentation included the desire to remain independent in her own home as long as possible, but to move into assisted living rather than in with her children, if needed, to maintain physical and social activity for the rest of her life. She developed a financial plan for her children to follow and put in a small down payment at the two living communities of her choice; she believed she would know if the time came to move.

The fracture episode and the elements of Hilde’s successful rehabilitation were well documented in her EHR, as were her goals. The entire multidisciplinary PCMH team knew her goals of care and her personal journey. And she knew the team would be readily available to her if she needed them. With the support of a PCMH, quality of life is possible for older adults, even for older adults facing a setback and multiple chronic conditions.

Hilde’s experience comprehensively demonstrates the social isolation older adults can experience, how vital it is to consider a patient’s wishes to age in place, and the importance of care plans. Testing for decline and the PCMH’s connection to community organizations for support gave Hilde the confidence to live on her own terms and potentially prevented further medical problems. Hilde was empowered by her PCMH, rather than sidelined as an elderly person. Hilde had developed hope and confidence.

The needs of older adults can be complex in that they are rooted in social and daily life concerns—that is, needs may have to do with social determinants of health (Healthy People 2020, n.d.). PCMH teams should strive to assess the web of CBOs available to older adults in the service area and make meaningful connections to them for referral. The PCMH does not need to reinvent social services that are needed by older patients and their families and caretakers. A person’s experience of health is deeply interwoven with housing, finances, transportation, exercise, and relationships with others. Non-medical issues outside of any health care provider make up more of the daily experience of life for older adults; rather than becoming overwhelmed, PCPs may equip themselves to address the reality of the patient’s experience.

The PCMH Model and Older Adults

The purpose of the PCMH is to position the primary care system to provide better health care, better health, and lower cost per capita coupled with high-quality, accessible, and efficient care for all patients. The PCMH is a promising model for transforming the organization and delivery of primary care.

However, national and local definitions of PCMHs have little or no focus on advance care planning, functional status, mental and behavioral health, or comprehensive assessments and interventions for older or medically complex patients, many of whom are frail and have multiple chronic conditions—these are older adults with medically complex needs. Family and caregivers also play a significant role in the care of older adults. This paper advocates for enhancing primary care for older adults, both with and without medically complex needs. Some, but not all, older adults would fall into the category of “geriatric,” particularly those at risk of frailty, a condition of vulnerability leading to increased risk of hospitalization, dependency, and reduced life expectancy (Xue, 2011). Older adults can quickly fall into frailty, but they also may make their way back to a less frail state with good care and appropriate support. The PCMH team should be ready to serve older adults both with and without medically complex needs because health status can quickly change for this population, although most older adults function well in communities of their choice. 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.

Patient Ecology

Older adults can, and usually do, lead satisfying lives, and, as such, their care would involve concerns for behavioral health as well as psychological welfare, including social contacts, economic security, and sense of belonging in the community—essentially, overall quality of life, both inside and outside of the clinic walls (Miller-Keane & O’Toole, 2005). Patient ecology, defined as the daily experience of life for older adults, is a vital concept to the PCMH caring for older adults. Patients spend a tiny proportion of their time with a health care provider, but health extends far beyond a brief office visit. Understanding

how older adults experience social, economic, and physical determinants of health can help guide PCMHs to better meet needs. Social determinants of health are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” such as safe and affordable housing, public safety, food security, patterns of social engagement, and sense of security (Healthy People 2020, n.d.).

Independence and Interdependence

Older adults often express a desire to live independently, but it is more accurate to state that older adults live in a community. Indeed, older adults are able to live independently because they rely on neighbors, friends, family, community, and CBOs, and thus live very much *interdependently*. All people are connected to the community in which they live, work, and play. Removing an older adult from the networked web of interdependence in which they live may result, as it did with Hilde, in isolation and depression. Part of this network is made up of family, friends, neighbors, groups (faith-based groups, for example), and other social outlets. CBOs are crucial especially for filling in the gaps outside of the PCP clinic walls and supporting older adults in their ability to enjoy a fulfilling, meaningful life in line with their values and goals. This concept—connection to CBOs—is new to the PCMH model.

Care Plans

In the care of older adults, there is an even greater need than in the general population to identify individual goals, preferences, and values—and, these goals need to be the focus of care delivery and care plans that guide care delivery. As Americans age and seek care from their PCPs, there may arise a disconnect between individual goals and treatment. In addition, an essential component of care for older adults is often an individual goal; oftentimes, individual goals are not elicited or addressed by care providers especially when care plans are being developed. Eliciting goals through conversation, rather than a PCP simply creating a care plan, is essential to capturing goals, preferences, and values. Conversations among PCPs, patients, and their family and caregivers will lead to a more patient-centered plan of care. Measuring health outcomes using traditional quality measures may be inappropriate to meet the needs of older

adults. By addressing these essential components of care delivery through PCMHs, older adults with complex needs will be able to live healthy lives with dignity and independence, in communities of their choice, and with sustainable costs for families and society.

Caring for an Older Population

As the U.S. population ages over the next 25 years, the number of Americans aged 65 years and older will double—and more than two out of three will suffer from multiple chronic conditions. Eighty-eight percent of the Medicare population have at least one chronic disease and three out of four older adults have multiple chronic conditions (Lochner & Cox, 2013). Even if conditions such as high blood pressure, high cholesterol, diabetes, and ischemic heart disease are managed well, all patients could benefit from management through a PCMH team. PCPs will be performing care for older adults with complex chronic medical needs, regardless of whether they acknowledge this fact. Establishing a PCMH to serve older adults will put in place systems to keep the entire population of patients healthier. A PCMH organized around serving the frailest and most complex patients will embrace healthier and younger populations; putting systems in place to benefit the population of older adults will benefit younger patients as well.

Although this concept paper will not focus on the specific efficacy of the PCMH model, a growing evidence base is developing regarding its effectiveness and the model continues to spread rapidly (Perla, Reid, Cohen, & Parry, 2015). The PCMH model offers evidence-based hope for progress. A study by Robert Reid of Group Health Research Institute compared more than 7,000 patients at a medical home with more than 200,000 non-medical home patients (Fleming, 2010). The study found that access to a medical home led to 29 percent fewer visits to the emergency department and six percent fewer hospitalizations.

The goal of this paper is to set forth a roadmap for the PCMH to enhance delivery of primary care to older, complex patients, some of whom have significant disabilities. It will build on the foundation established by existing quality and performance improvement in PCMHs. The paper will discuss the approach needed to recognize, facilitate, and encourage improved care and outcomes for older adults by providing person-oriented care; in an ideal PCMH caring for older adults, the care will be patient-goal directed and inclusive of connections to CBOs for support.

COMPONENTS OF THE PCMH

The medical home encompasses five functions and attributes:

1. Comprehensive Care

- The PCMH is accountable for providing most of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- *Provider-directed medical practice teams* on the frontline of medicine that take responsibility for the ongoing, comprehensive care of each patient have been shown to improve care and outcomes.
- *Personal provider teams* are trained in the provision of personalized, comprehensive care for both wellness and illness. Long-term physician-patient relationships are key to the success of the medical home.

2. Patient-Centered Care

- The PCMH provides primary health care that encompasses the needs of the whole person. This requires understanding and respecting each patient's unique needs, culture, values, and preferences.
- *Whole-person orientation* refers to the role of the PCMH team in providing for all health care needs and arranging care with appropriate other qualified providers.

3. Coordinated Care

- The PCMH coordinates care and treatment by providers, including those in the health care system, such as specialty care, hospitals, home health care, and community services and supports. This coordinated care also occurs across transitions between various sites and levels of care.
- *Coordination of care* includes integration across all elements of the complex health care system and the patient's community.

4. Accessible Services

- The PCMH delivers accessible services for urgent care needs, including telephone or electronic access to a member of the care team.
- *Access to care* is enhanced through systems such as open scheduling, expanded hours, bringing health services to the neighborhoods where people live, use of team members at the top of their respective licenses, and new options for communication between patients, their personal physician, and practice staff.

5. Commitment to Quality and Safety

- The PCMH has a focus on quality improvement and patient safety by use of evidence-based medicine and clinical decision support tools, use of shared decision making with patients and families, performance measurement and improvement, including patient experiences and patient satisfaction, and practicing population health management.
- *Quality and safety are the hallmarks of the PCMH.* Safety and quality are foundational in providing good care.

TABLE 1. Special Considerations for an Aging Population, Challenges, and Opportunities

Table 1 describes challenges and opportunities for improvement in treating older adults through PCMHs and serves as an information shortcut.

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: <ul style="list-style-type: none"> ▪ <i>Home-delivered/congregate meals</i> ▪ <i>Transportation</i> ▪ <i>Medication review</i> ▪ <i>Respite/caregiver support</i> ▪ <i>Falls/home risk assessments</i> ▪ <i>Information and assistance</i> ▪ <i>Personal care</i> ▪ <i>Employment-related supports</i> ▪ <i>Housing</i> ▪ <i>Homemaker</i> ▪ <i>Shopping</i> ▪ <i>Money management</i> 	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

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

This concept paper will describe the essential elements of a PCMH enhanced for the care of older adults, identify approaches for the PCMH to meet the needs of older adults, and recognize areas of opportunity for PCPs to begin this work. The ultimate goal is to improve care for older adults (Patient-Centered Primary Care Collaborative [PCPCC], 2015a).



Components of the Patient-Centered Medical Home: Considerations for an Aging Population

COMPREHENSIVE CARE

Comprehensive care is an essential feature of the PCMH and refers to a team of care providers accountable for meeting each patient's physical and mental health care needs (PCPCC, 2015a). The PCMH model advocates for a personal physician who leads a primary care team responsible for developing and overseeing comprehensive, individualized patient care plans that include prevention, wellness, acute care, and chronic care. With the patient's advancing age, the burden of chronic disease can lead to a long period of decline and disability with increasing caregiving needs by family and professional caregivers. Common problems in aging—both medical and social determinant—include physical and social inactivity, falls, functional status, medication mismanagement, poor nutrition, urinary incontinence, depression, elder abuse, social isolation, lack of transportation, lack of financial stability and resources for essential needs, memory problems, and lack of advance planning. This broad array of needs increasingly challenge PCMH teams. Providers want to provide the best possible care for all their patients, with considerations for socioeconomic status, cultural preferences, age, and medical complexity. What role can and should PCMH teams play in the overall health and well-being of the older, and often complex, patients they serve?

Resource: Health & Human Services Framework for Multiple Chronic Conditions

The U.S. Department of Health and Human Services recently released Education and Training Resources on Multiple Chronic Conditions for the health care workforce that will provide health professionals with education to care for people living with multiple chronic conditions; these resources are for use by health care curriculum developers, educators, trainers, students, and practitioners.

<http://www.hhs.gov/ash/initiatives/mcc/>

Framework for Understanding Comprehensive Care

The chronic care model (CCM) summarizes the basic elements for improving care in health systems at the community, organization, practice, and patient levels (Group Health Research Institute, MacColl Center for Health Care Innovation, 2016). This model served as an underpinning and precursor to the idea of comprehensive care in the PCMH model.

To achieve optimal health outcomes, the CCM model emphasizes the importance of *productive interactions* between an *informed, activated patient* and a *prepared, proactive practice team*. Elements of the CCM that support the patient and practice team include the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. The health system's role is to visibly support a culture of safe, high-quality care and develop agreements to facilitate care across organizations. Delivery system design should be culturally appropriate, proactive, and focused on keeping a person as healthy as possible. Good design defines team member tasks, provides evidence-based care and self-management support, and offers clinical case management to complex patients. The decision-support component promotes the use of evidence-based guidelines and patient preferences, along with patient participation in decision making. Clinical information systems should ensure ready access to data on individual and population-level patients, along with timely reminders for providers. When combined with consideration for older adult care, the comprehensive care framework is a powerful tool for thinking through how to best support older adults and their families and caregivers.

Attributes of PCMH Comprehensive Care for Older Adults

While there are many attributes of comprehensive care that are important to caring for older adults, four are described here: PCMH teams, CBOs, delivery design that includes evidence-based assessments and patient-centered care plans, and advance care planning. For each attribute, best practices are described and practical suggestions are provided for incorporating these improvements into the PCMH.

PCMH Teams and Comprehensive Care

Comprehensive care, facilitated by PCMH team members, is essential to both acute and ongoing care for older adults. PCMH teams with long-term patient relationships can have a significant effect on functional decline and disease management. PCMH teams can guide and activate patients toward self-management of chronic diseases and disabilities. Optimal teams would be able to draw upon the expertise of multiple health care providers including the physician, mid-level provider, nurses (RN, MA, licensed practical nurse), social worker, pharmacist, and receptionist, as well as behavioral health, physical therapy, occupational therapy, speech therapy, and possibly patient volunteers. Cross-training team members in counseling and follow-up reminder systems for patients can be facilitated by EHRs. Patients and families are central members of the care team and often are caregivers, and thus they need to be offered tools and support to fulfill their roles and responsibilities.

To provide the best possible care, PCMH team members should be conscientious about listening to the concerns of older adults. Societal biases regarding aging can lead health care providers, families, and patients themselves to dismiss health and social problems as "just getting old." Shared decision making, an essential skill for members of the PCMH, can be a useful tool for avoiding problems of undertreating or overtreating. Keeping the care plan and older adult's goals at the forefront can help ensure that care is personal and tailored to each patient.

Community-Based Organizations and Comprehensive Care

Essential partners for the PCMH team are the abundant CBOs that provide multiple services and supports to older adults and their families. Area Agencies on Aging and many other CBOs provide

long-term services and supports (LTSS) as well as health, financial, and social programs that help older adults manage the many challenges associated with aging. CBOs vary by locality; other options in a community may include a United Way, senior center, or faith-based organization. The integration of CBOs into the PCMH referral system can help individuals to achieve their goals. CBOs focus on social support systems that attend to prevention, wellness, and chronic disease management, and thus address issues of daily life.

CBO programs and services can improve patient outcomes by activating patients, avoiding both short- and long-term nursing facility stays, and preventing unnecessary hospital admissions (Parekh & Schreiber, 2015). Programs offered by CBOs are often located conveniently, and staff is attuned to cultural preferences (Coleman, Whitelaw, & Schreiber, 2014). Partnerships between PCMHs and CBOs fill gaps in needed services and meet the social dimension of older adults' needs. For example, a PCMH partnership with a senior center can alert older adults to evidence-based classes on chronic disease self-management, fall prevention, and physical activity.

Research has demonstrated that partnering with CBOs can be highly effective in improving health outcomes and patient satisfaction. In the 1990s, a randomized controlled trial, the Health Enhancement Project, enrolled adults ages 70 years and older in a geriatric syndrome screening, assessment, and intervention program at a senior center led by a nurse. Each patient was personally interviewed and referred to a variety of the center's programs and community-based assistance, including: the center's exercise program, the Stanford Chronic Disease Self-Management Program, social activities, meeting with a social worker for depression screening, advance planning classes, memory classes, and others. All screening and interventions were reported to the PCP. In less than a year, the health satisfaction of the patients and patient efficacy increased dramatically. At the same time, health care costs decreased 50 percent from the prior year, largely due to decreased hospitalizations. This partnership involving a senior center, health care system, and researchers continues to be a vital model (Leveille et al., 1998; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, n.d.).

A PCMH need not reinvent programs that already exist in the community. CBOs and PCPs have the ability to maintain two-way communication through referrals and formal agreements that are compliant with the Health Insurance Portability and Accountability Act. CBO staff can provide patients with reinforcement for healthy behaviors and encourage disease self-management. Furthermore, PCPs can now bill under Medicare for coordinating these services.

National Council on Aging Toolkit

The National Council on Aging developed a Toolkit for Physician Champions on partnering physicians with community organizations. The purpose of this toolkit is to guide a physician "champion" in educating colleagues about the benefits and practicalities of collaborating with CBOs that serve older adults.

https://www.adrc-tae.acl.gov/tiki-download_file.php?fileId=27090

Assessment and Patient-Centered Care Planning in Comprehensive Care

The design of the PCMH model facilitates systematic screening, assessment, and patient-centered care planning at the Annual Wellness Visit (AWV). Preventive care provided at the AWV includes immunizations, weight tracking, blood pressure tracking, and age/sex appropriate cancer, bone density, and cholesterol measurement. Depression and other behavioral health screenings also should be completed. Pain should be monitored at every AWV because of its negative effects on functional ability. PCMH teams should cross-train multiple team members to play various roles in the AWV screening, assessments, and interventions, promoting similar messaging to patients and their families and continuity of care. For older adults who are frail or suffering from multiple complex conditions, the AWV can include geriatric assessments. The geriatric assessment is "a multidimensional, multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances" (Elsawy & Higgins, 2011). These appointments are generally lengthier because of their complexity, but there is a payment structure in place for PCPs to bill for these visits.

Behavioral health screenings, including screening for depression, are needed because older adults may be experiencing grief, loss, addiction, mental illness, social isolation, and/or a lack of engagement in the community. From 15 to 20 percent of older adults in the United States have experienced depression (American Psychological Association [APA], 2016). Approximately 11 percent of older adults have anxiety disorders (APA, 2016). And, even mild depression lowers immunity and may compromise a person's ability to fight infections and cancers (APA, 2016). Rather than be intimidated by the breadth of these needs, PCMHs have a unique opportunity to connect older adults to community resources and specialty providers and dramatically improve quality of life for this population.

Alzheimer's Association Annual Wellness Visit Tools

The Alzheimer's Association has recommended assessment tools to help clinicians detect cognitive impairment during the Medicare AWV and other useful tools.

<http://www.alz.org/health-care-professionals/clinical-guidelines-information-tools.asp>

Comprehensive care provided by PCMHs should recognize the ecology of a person's daily experience beyond the clinic walls. The most potent predictors of quality of life and overall health outcomes are social connection and physical activity. It is useful to note that in Sweden, when chronic diseases are newly diagnosed, providers often write a three-month prescription for increasing physical activity prior to prescribing medications (Kallings, Leijon, Hellenius, & Stahle, 2008). Evidence-based self-management and prevention programs, such as the Stanford Chronic Disease Self-Management Program, foster patient activation and better health (Stanford Patient Education Research Center, 2016). This program is helpful for patients with one or more chronic conditions because it provides the tools and teaches the skills needed to coordinate health and maintain activity. Improving health literacy has similar effects.

Comprehensive Care in Action

Comprehensive care has the capacity to effect change in all aspects of a patient's daily experience. For example, consider this true-life example from

a provider in Illinois. An outpatient licensed clinical social worker (LCSW) met with a patient during his hospital stay to introduce social work services and identify potential patient needs post-discharge. The social worker learned that although the patient lived with a caregiver, the patient was not receiving many of the financial benefits he qualified for through various programs. The LCSW assisted the patient's caregiver in navigating various federal, state, and local systems to enroll the patient in benefit programs applicable to his situation. As a result, the patient was better able to regularly afford the blood pressure medication prescribed by his PCP. Following this intervention, the physician noted increased medication adherence and, in turn, more stable blood pressures and fewer hospitalizations of the patient.

Advance Care Planning in Comprehensive Care

Advance care planning for serious illness and end-of-life care is an essential component of the PCMH enhanced for older adults. Challenges to facilitating advance care planning include complicated issues around advance directives, such as parents and children disagreeing over treatment, palliative care and hospice, and Physician Orders for Life-Sustaining Treatment (POLST). Care plans may change over time, as described by Harry, a real patient. As Harry's condition changed, so too did his wishes for care. Earlier in his life, he ran several not-for-profit organizations. After retirement, he developed some chronic medical problems, and sat down with his wife and PCP to make his goals, values, and preferences for care known. Several years later, Harry developed non-Hodgkin's lymphoma. He chose to be relatively aggressive about treatment options as long as he had some independence and quality of life. He accepted chemotherapy and radiation therapy. Harry again made it clear that he chose not to undergo aggressive therapies with a low chance of cure just to gain more time. After about two years of treatment, Harry decided that further treatment was not worth the loss of quality of life. The treatment offered had only a 10 to 20 percent chance of working, had significant risks, and almost always produced severe nausea. Soon after that decision, Harry developed a massive bleed into his brain and it became clear that if he survived, he would be totally dependent and require a feeding tube. His family and health care team honored his wishes and discontinued life support measures. Harry passed away with his family surrounding him. Harry was able

to determine his care up until the end of his life with clear goals, even as they changed over time. Advance care planning made his end-of-life experience possible.

Medicare is now reimbursing for voluntary advance care planning done between a physician or other qualified health care professional and the patient. This is an optional element of the AWV. It can be billed in addition to the AWV or separately billed under the Medicare Physician Fee Schedule.

RECOMMENDATIONS

Active steps a clinic may consider in enhancing comprehensive care include:

1. Employ delivery systems that are proactive, culturally appropriate, honor a patient's goals and preferences in development of a care plan, and invite patient participation in decision making.
 2. Partner with CBOs that provide support to older adults and their families and caregivers to fill in gaps in care.
 3. Use the AWV to assess and plan for care.
 4. Initiate conversations about advance care planning, and recognize that wishes may change over time.
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PATIENT-CENTERED CARE: THE PERSON IN THE CENTER

Older Adults' Experience of Health

From the provider's point of view, the PCMH is designed to be a physician-led, team-based health care delivery model, which provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. A PCMH as discussed here would enhance care for older adults. This encircling model of care is a substantial improvement over the fractured, episodic, and uncoordinated care that is the norm for older adults dealing with multiple chronic conditions. For example,

fractured care could mean that the PCP, hospital system, and specialty providers do not communicate effectively, or at all, about a patient. Episodic means addressing issues as they arise in a haphazard manner, operating without a comprehensive plan for care of a patient. And, uncoordinated care may lead to mistakes, overtreatment, and poor outcomes. Patients who see multiple physicians, who are in and out of acute care settings, and who have multiple chronic diseases and accompanying medications are most likely to experience poor care.

FIGURE 1. Health Professional View of Wrap-Around Care for Older Adults in the Patient-Centered Medical Home Model (Source: Sara Riggare's Blog)

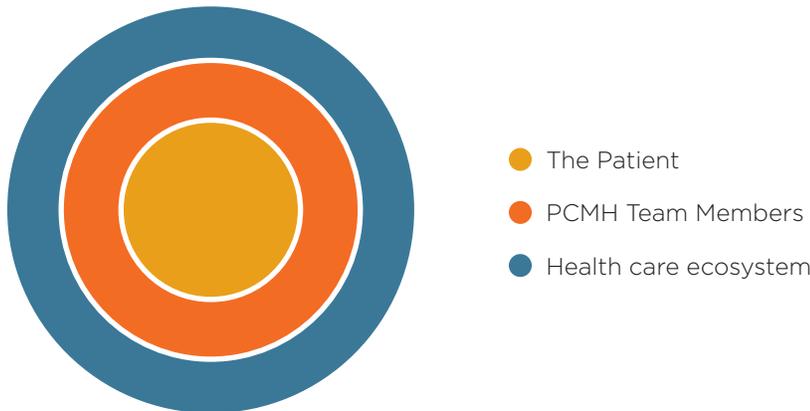
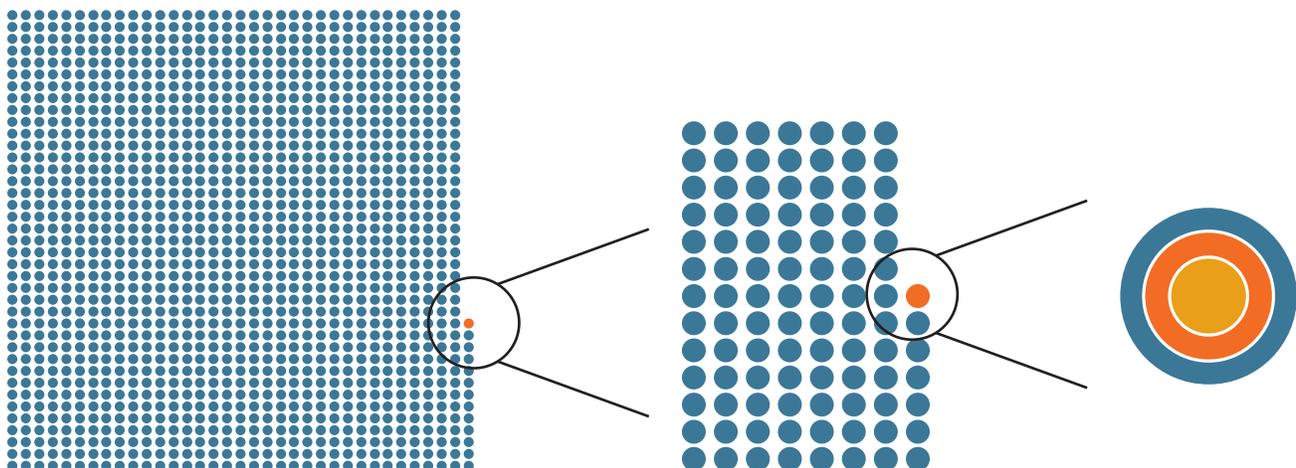


FIGURE 2. Visual Representation of Time Spent at PCP

1 hour vs. 8,765 hours in a year: A patient's experience of medical care for a chronic condition in the context of her entire life. (Riggare, n.d.).



Time spent in a physician's office or clinic is only a fraction of a person's life experience; the same is true for caregivers and family members who care for them. Figure 2 represents the small proportion of time that a patient spent at a physician's office in a year. Sara Riggare, a Swedish engineer, was diagnosed with Parkinson's disease, and has chronicled self-care and its role in her life in her blog. "I see my neurologist twice a year, about half an hour every time. That's one hour per year in health care for my Parkinson's disease. During the same year, I spend 8,765 hours in self-care, applying my knowledge and experience...to manage a difficult condition as best I can," says Riggare. In her blog, Riggare makes a case for recognizing the full-time efforts people make to participate in their health and health care: "Just imagine what we could achieve if we start working together—as equals with different but complementary areas of expertise!" (Riggare, n.d.). Although Riggare is not an older adult, her experience illustrates a larger point about the experience of a patient in the medical system. The clinical health care delivered through a PCMH is only a small part of the vast ecosystem of self-care. Developing a clear understanding of the evolution over the life course can inform any conversation about person-centered care.

"The patient's life is a story in which health care only intermittently plays a role. Care means something more."

—John Krueger, MD (Krueger, 2011)

Whole-Person Orientation

The Joint Principles of the PCMH refer to the needs of the whole person as "each person's unique needs, culture, values, and preferences" (PCPCC, 2015a). The Principles also suggest that the PCMH employ a *whole-person orientation*, which calls for the PCMH team to provide for all health care needs and arrange care with other appropriate providers. An issue of concern is how the PCMH model can best serve the older adult in the context of the individual's complex daily life, which might include moving pieces such as access to formal and informal caregivers, living independently or in assisted living, multiple chronic conditions, increasing frailty, and the need for advance care planning. For the whole-person orientation to be fully realized, a constellation of family members and caregivers must be involved in the care of the older adult.

The Conversation Project

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

<http://theconversationproject.org/#sthash.ijV0rxNP.dpuf>

In a generic conversation about access to care, individuals engaged in self-care frame it as an issue of *convenience*. For example, the rise of retail clinics exemplifies the needs of busy families to get care on their terms later in the evenings or on weekends. Another example is the rise of advertising by hospitals or urgent care facilities about their short wait times and convenience. Many offer online scheduling options. Neither of these types of facilities works well for addressing the medical needs of patients with complex chronic diseases and their family caregivers. Successful primary care tends to involve forming long-term relationships between patients and providers. Traditional medical offices and home care visits are a better option for quality care for complex patients because the physicians who understand particular patients' comorbidities and histories are accessible. Traditional PCP hours, however, do not fulfill the needs of family caregivers who work during the daytime.

Patients and providers use similar words to describe patient-centeredness, but mean different things—importantly, they tend to have different ideas about what patient access means, according to Millenson (2012) of the National Partnership for Women and Families. Based on the common structure of specialty practices around the world, *access* means readily available referral. Accessible to a caregiver might mean convenient in terms of time and money to a patient and his or her family.

The Care Plan and Goals

Developing a care plan for each older adult is essential for the PCMH to provide care for older adults. Achieving a good quality of life may be most important to an older patient yet may not align with the medical goals. For older adults, a more useful framework may be goals that matter most to the individual. Goals could include life activities, such as visiting friends, family, and grandchildren, or accomplishing certain life tasks, in contrast with meeting standard quality metrics. Goals may deviate from established quality metrics and PCPs should

be prepared to recognize this factor. Patient goals may change over time and should be constantly re-evaluated with the care team, patient, and family and caregivers. While goals may change, values tend to remain constant. PCMHs should consider adding patient goal-directed care plans that are used across all settings. The elicitation of goals needs to be done properly by the PCP team, as described later in this concept paper in the [Quality and Safety section](#). Additionally, older patients tend to be the frailest, and so incorporating the family and caregiver role is essential in a generic PCMH setting. Care plans and goals should drive care for older adults and should appear conspicuously in any EHR to keep goals at the forefront.

RECOMMENDATIONS

Active steps a clinic may consider in achieving care coordination goals include:

1. **Whole-person care:** care that aligns with the patient's values and preferences, and care that accounts for the full range of factors that affect a person's ability to get and stay well.
 2. **Care coordination and communication:** effective team care, smooth transitions between care settings.
 3. **Patient support and empowerment:** self-care management, shared decision-making tools, and support for patients and caregivers.
 4. **Ready access:** access to care when needed, preventive services reminders, and prescription management.
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COORDINATED CARE

Care coordination includes the facilitation, management, and organization of services within the health care system, including specialty care, hospitals, home health care, LTSS, and other medical settings; within the community, including CBOs, community services, and governmental agencies; and between settings for transitions in care. Care coordination holds the promise of helping PCPs achieve the Institute for Healthcare Improvement's Triple Aim of better care, lower costs, and better population health (Institute for Healthcare Improvement, 2016). In the population of older adults, the care plan should serve as the guiding document for all care coordinated by the PCMH team. Unfortunately, an estimated 80 percent of Medicare beneficiaries lack access to team-based care coordination of services.

Defining Care Coordination

Care coordination is a person- and family-centered, multicultural, assessment-based, interdisciplinary process that aims to integrate health care and social support services in a comprehensive plan using evidence-based processes (Rush University Medical Center, 2016). A consistent care coordinator typically leads the process with each given patient. The care coordinator could be an RN or advanced practice nurse, a social worker, a community health worker, a gerontologist, or the PCP. To be effective, care coordinators must have the skills and time to build rapport with patients and families and be able to assess for both medical and non-medical issues that a patient may be experiencing. Care coordination is usually considered a professional role and responsibility by nurses, social workers, and administrative staff who are able to bring many skills and resources to this job.

It is commonly assumed in a care plan, but not explicitly recognized, that family caregivers will play an important role in care coordination. This role of the family caregiver in coordinating the older adult's care is often a major activity for family caregivers and most of them are performing this work alone (Reinhard, Levine, & Samis, 2012). As a result, PCPs need to assess the family and caregiver abilities and resources to provide this service. The care coordinator must be able to navigate systems, help develop organizational partnerships with other agencies and clinics, and

build personal inter-professional relationships to best intervene on patients' needs in a timely manner. Specific to a population of older adults, care coordination should follow a goal-directed care plan.

Importance of Care Coordination

The PCMH model requires increased care coordination to improve efficiency and collaboration in care for patients with complex needs. Care and services must be intentionally coordinated and integrated into the patient's primary care plan. The PCP-led team is the consummate mechanism for this role. As a place where patient-team relationships are built and records and care plans are facilitated, the PCMH is the best possible place to coordinate care for older adults. It is important that a medical provider considers non-medical concerns so that the whole-person view of care is realized. The PCMH team needs to know about daily wellness activities that a patient undertakes, such as attending an exercise class or beginning talk therapy for anxiety about grief. Additionally, it is imperative that PCMHs work toward these goals and develop partnerships with CBOs, Area Agencies on Aging, LTSS providers, and health systems in order to make these programs effective and efficient. As later discussed, clinics must move beyond simple partnerships.

Care Transitions

Facilitating safe, coordinated care among treatment settings through the PCMH is an essential component of care coordination, especially for older adults who may be more complex in their health conditions and needs for support. A lack of follow up after an acute episode or miscommunication among providers can put patients at risk for complications and hospital readmission. Older adults who suffer from depression, social isolation, or a lack of housing or transportation have an increased risk of hospital readmission. Fragmentation in the health care system results in "omissions in care, exposure to unnecessary procedures, excessive use of medications, and care by health care professionals who are often unfamiliar with the complex medical history and psychosocial issues of the older adult patient" (Wohlauer et al., 2012). PCMHs can improve communications in collaborations with specialists; good communication is crucial to implement the Joint Principles of the PCMH (American

Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012). A care transitions coach who monitors patients and flags patients at higher risk—based on a history of hospitalizations, types of conditions, and quantity and type of medications prescribed—may be particularly useful for the older adult population (Aligning Forces for Quality, 2013). PCPs may also consider an electronic messaging or another automated system with area hospitals. Rather than waiting for information passively, PCPs may reach out to hospitals and recently discharged patients.

Role of the PCP Care Coordinator

PCPs may identify high-risk patients and offer different levels of care coordination based on patient need. The care team can help assess for patient and caregiver LTSS and social support needs, such as in-home caretaker hours, transportation to appointments, and socialization opportunities. They collaborate regularly with the CBOs that provide LTSS to ensure coordination with medical care and identify cases where individuals could benefit from these types of supports. Care coordinators may also identify caregivers who need support and refer them to CBO support.

Care coordinators may offer information on transitional care programs that specifically target patients' needs as they transition home into the community—or perhaps to a short-term skilled nursing facility—after a hospitalization. Care coordinators focus on health literacy with patients and families, and they advocate on behalf of patients in navigating the health care and benefits systems. Finally, care coordinators engage patients and families in discussions with the inter-professional team to ensure true collaboration and the development of realistic and adequate care plans to meet patient goals.

True coordinated care will look beyond the clinic walls. Consider the following true-life case from Illinois of Kathy, an older adult. An LCSW worked closely with Kathy's PCP to perform a comprehensive psychosocial assessment following her annual physical exam. The LCSW learned through assessment that Kathy was participating in high-impact aerobics activities, instead of low-impact aerobics activities, three times per week. Through additional conversation, the LCSW discovered

that Kathy felt she was following the PCP's orders to "exercise;" however, she did not understand the various types of exercise most appropriate for her tender joints. After the LCSW relayed this information to the PCP, Kathy and PCP were able to discuss appropriate and safe activities for the patient that would greatly reduce her joint pain and pain medication use. After reducing the amount of pain medication she was taking, Kathy noted decreases in constipation, drowsiness, and nausea. In an additional follow-up call made to the patient by the LCSW, Kathy stated she was thankful for the care coordination taking place outside of the physician's office and believes the extra communication improved her daily quality of life. This case illustrates the opportunity presented by coordinating care and considering all patient needs comprehensively. This solution is simple, low cost, and only possible when looking comprehensively at a patient's whole experience and daily life activities.

A care coordination initiative needs to be effectively built into the clinic workflow so that it is not viewed as an afterthought. It must dependably integrate the entire interprofessional team. Moreover, to be effective for older adults, care coordinators need to have timely information on patients' hospital and emergency department visits as well as home assessments by LTSS agencies and Visiting Nurse Associations. All this information is ideally integrated into a clinic's EHR to ensure consistent information is available to all providers.

Role of Health Information Technology (HIT)

Care plans should be kept and displayed prominently within all HIT systems. Ideally, patients and caregivers should be able to enter their own notes into the EHR, and the EHR should be interoperable. Rather than a one-way dissemination of information, from PCP to patient, the EHR can facilitate an ongoing back-and-forth conversation. This strategy allows for true continuous comprehensive care. In a promising development, billing for care coordination is now possible through Medicare.

Challenges to Coordinated Care

Despite the momentum toward including more care coordination into health care, significant challenges remain. There have been mixed results from the Center for Medicare and Medicaid Innovation pilot programs

regarding cost savings. While sites are implementing risk stratification strategies and often target high utilizers, care coordination interventions need to determine how to best target interventions to different populations and patient needs. Larger systemic challenges exist as well; older adults face economic security challenges, and there is a growing shortage of family caregivers. Additionally, many communities were not designed to be “age friendly.” Moreover, geriatric workforce shortages, rural service delivery, and provider coverage are challenges to consider when PCPs develop their teams and seek partnerships with other organizations and providers.

AARP Network of Age-Friendly Communities List

A growing number of cities and communities nationwide are striving to better meet the needs of their older residents.

<http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/member-list.html>

Programs that oversee and coordinate care present promising approaches to addressing various challenges that face the health system today. The rate of individuals experiencing multiple chronic conditions, particularly older adults, is increasing. These conditions come with rising costs to the system as well as to patients and families. Hospitalization rates are high, and hospital readmission rates within 30 days, while on a decreasing trend, still linger above 15 percent for Medicare beneficiaries. Furthermore, traditional medical clinics and hospitals remain isolated from community-based social services that older adults often rely on for social support and engagement opportunities; this separation stems from many causes, including different historical payment systems and provider training (Robert Wood Johnson Foundation [RWJF], 2011).

Mental health concerns should be addressed, particularly with older adults. Depression and other mental health screenings should be administered, and affected patients should have access to a wide referral network for support through the PCP.

Many communities struggle with finding culturally relevant and culturally competent care. While individual clinics and providers are certainly not to blame for these issues, they can play a leadership role in initiatives that help to fill in some of these gaps—and it is imperative that they do so in order to reach their quality goals. A PCP-led initiative that actively collaborates with other professionals such as hospital discharge planners, home health nurses, and staff at the local Area Agency on Aging can help ensure the wide range of patients’ needs and wants are being assessed and addressed.

Patient Priority Care

Patient Priority Care (formerly CaReAlign) is a patient health outcome goal and preference interoperability and informatics platform helpful for older adults with multiple chronic conditions. It is designed to be embedded in care delivery systems that need infrastructure and relationship management to align primary and specialty care.

<http://www.jhartfound.org/blog/tag/care-align/>

Recent Examples in Care Coordination

There are many mechanisms and models to look to as examples of successful care coordination efforts. Many are informed by other efforts outside of the PCMH model:

- **Federal:** The Affordable Care Act and other federal reform initiatives have promoted care coordination through various demonstration projects in the Center for Medicare and Medicaid Innovation (such as the Comprehensive Primary Care Initiative and the Federally Qualified Health Center Advanced Primary Care Demonstration).
- **Federal:** The Veterans Health Administration has been working to improve coordination for veterans with dementia; this program coordinates a variety of services, such as home-based primary care, homemaker and home health aide, caregiver support and respite, adult day health care, outpatient clinic, inpatient hospital, nursing home, and hospice care.
- **State:** Vermont has had much success with its program Support and Services at Home (SASH), a model based out of residential units that offers a care coordinator and wellness nurse and collaborates with community providers.
- **Community:** The Bridge Model of transitional care was launched in 2008 by a partnership of six organizations in Illinois (Altfeld, Pavle, Rosenberg, & Shure, 2012). It focuses on after-hospital transitional care and is led by a social worker based in a hospital, a CBO, skilled nursing facility, or clinic. Rush University Medical Center, a Bridge Model founding organization, has since captured its translated lessons learned to develop an effective primary care-based care coordination initiative that helps to meet National Committee for Quality Assurance certification criteria, called the Ambulatory Integration of the Medical and Social (AIMS) model.

First Steps for PCPs

Many projects and initiatives have developed and shared useful information for clinics looking to integrate more care coordination into their practice. For instance, the Comprehensive Primary Care Initiative created a list of milestones for clinics as they develop their programming (Comprehensive Primary Care Initiative, 2016). Evidence-based programs often offer training, technical assistance, and peer learning collaboratives to support the replication of the care coordination initiatives in organizations across the country. PCPs interested in improving care coordination need not start from scratch.

Another first step for PCPs interested in better coordinating care for an older adult population is to find out what resources already exist in the community to support older adults. An assessment of the needs of older adults should guide this research. Is the primary issue for older adults a lack of public transportation, or a lack of social support and social outlets? The PCMH team should find, encourage, and link to CBOs that support older adults.

Providing care that is comprehensive and coordinated is at the heart of a PCMH. While historical barriers and systemic challenges exist, the momentum of the increasing number of clinics expanding their scope of care and better coordinating social and medical services has the power to truly transform how primary care is provided to older adults (U.S. Government Accountability Office, 2015).

Caring for Seniors: How Community-Based Organizations Can Help

This article offers tips and resources on how to help initiate or solidify PCP-CBO partnerships, including ways to find local CBOs and templates for referrals to CBOs.

<http://www.aafp.org/fpm/2014/0900/p13.pdf>

RECOMMENDATIONS

Active steps a clinic may consider in achieving care coordination goals include:

1. Assess regularly for the care coordination needs of older adults and caregivers.
 2. Form ongoing relationships with CBOs, such as Area Agencies on Aging, and identify and refer appropriate patients. This could include hiring staff from the Area Agency on Aging and integrating them into the care team delivery system.
 3. Facilitate transitions of care by establishing relationships, including written agreements with specialty care, local hospitals, and long-term care settings.
 4. Complete active outreach and monitoring of transitions.
 5. Expand the PCMH team with specific care coordination-focused roles integrated into the team.
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ACCESSIBLE SERVICES

Good health care must, by definition, take place at the right time for a patient, which means it needs to be accessible. Access to care is here defined as patients might view it: short waiting times, lengthened office hours, and around-the-clock telephone or electronic access to the PCMH team, including after hours (PCPCC, 2015a). Research has found that increasing support to PCPs to enhance after-hours care reduces rates of emergency department use and unmet medical need. Specifically, patients who reported less difficulty contacting a PCP after hours experienced significantly fewer emergency department visits (30.4 percent versus 37.7 percent) (O'Malley, 2013). To that end, PCPs should consider the availability of same-day appointments and adjust hours of operation to accommodate older adults and their families and caregivers. In addition, patients (and the PCMH team) need access to community support services that allow for patient needs to be met in their homes.

To become competent in the care of older adults, PCMHs should transition from focusing on episodic or acute care to continuous relationship building, with the care plan and the patient, family, and caregivers at the center. A consumer-friendly focus on accessibility of services and convenience should be part of the PCMH's design. In turn, enhanced access has the potential to impact health through an increased focus on wellness and prevention. The PCMH should be sensitive to patient preferences regarding access (Agency for Healthcare Research and Quality, n.d.). Change is needed to ensure that older adults are able to benefit from enhanced access to timely and goal-directed care, which thus may lead to reduced hospitalizations and a decreased numbers of acute care situations.

Streamlining Access

The Aging and Disability Resource Centers initiative is a collaborative effort led by the Administration for Community Living and the Centers for Medicare and Medicaid Services. This initiative seeks to streamline access to LTSS for older adults, all people with disabilities, family caregivers, veterans, and LTSS providers.

<http://www.adrc-tae.acl.gov/tiki-index.php?page=HomePage>

Changing Visit Design

Several barriers remain to PCPs achieving accessibility. Firstly, fee-for-service reimbursement disincentivizes streamlining of care by rewarding multiple visits on multiple days. This form of practice may be profitable for PCPs, but it presents problems for older adults. Older adults often have significant difficulty meeting with multiple providers on different days due to transportation challenges as well as the more limited availability of caregivers and other stakeholders in their care. Spreading care across multiple sites and providers is burdensome for older adults and limits their ability to benefit from team-based care, as communication may break down when multiple providers are involved in treatment. For a PCMH caring for older adults, the focus should be not only on access for the patient, but also for family and caregivers.

Secondly, PCPs are challenged in caring for complex, multi-morbid, older adults due to time constraints of visit duration. Again, fee-for-service incentivizes shorter office visits, and complex patients may benefit from longer visits for comprehensive assessment, education, treatment, and discussions on ways that different treatment options may fit within the context of the individual's care goals. Notably, many PCPs are uncomfortable providing comprehensive geriatric assessments (Elsawy & Higgins, 2011). In lieu of a comprehensive geriatric assessment, a PCP may perform a shorter primary care assessment as appropriate. A primary care assessment will be less time-intensive and may be appropriate depending on the needs of the patient. PCPs should consider routine mental and behavioral health screenings, because these are particular concerns in this population.

Thirdly, access for older adults based on physical space within the clinic is an issue to consider. Can an older adult with a walker, wheelchair, cane, impaired vision, or impaired hearing easily access the PCP? Because of physical challenges, older adults may need longer appointments to allow them sufficient time to navigate hallways and other enclosed spaces, get undressed, and use the bathroom.

Another aspect of improving access concerns changing methods of contact and communication so that family and caregivers are consistently included. PCMHs should consider developing a telephone system to reach patients and family and caregivers simultaneously. To simplify this system for older adults, patients should have one point of contact within the PCMH who can connect them with an appropriate team member, any time of day or night as suits the urgency of their need.

Lastly, workforce issues also present a barrier to providing access to care for older adults as shortages in geriatric-trained PCMH team members limit access. The scarcity of health care teams that are optimally trained to triage problems in high-risk older adults and allocate resources appropriately is well-documented. The number of PCPs trained through geriatric fellowships is decreasing, but the overall numbers of PCPs exposed to some geriatric educational training is increasing. However, a month of training in geriatrics may not be enough to meet the workforce needs of the future. In 2013, the ratio of certified geriatricians to adults 85 years of age or older was 1:870 (Brittain, 2013). Additionally, many certified geriatricians are not practicing primary care; they may work in hospitals, in home and palliative care, teaching, or consulting instead. To more optimally meet the rising demand, an ideal ratio of geriatricians to older patients would be 1:300 (Brittain, 2013). Demographics are driving the need for increased workforce in geriatric care, which is a prerequisite to accessible care. By 2030, the older adult population is projected to grow to more than seventy million Americans—one in five people (Boult, Counsell, Leipzig, & Berenson, 2010).

Rethinking Access with Technology

PCPs should provide patient access to non-urgent medical advice through email, telephone consultations, and related means. Importantly, all care does not have to be provided in the clinic. As a matter of convenience for both older adults and their families, telehealth or e-health visits have the potential to revolutionize care access. For example, the Alzheimer's Association is partnering with several PCMHs to provide virtual social worker consultation for recently diagnosed dementia patients and their families. Social workers will provide education, information, and support services.

A patient-facing EHR is also a potentially useful method for clinicians and patients to share information and thereby enhance the availability and accessibility of medical information. With the advent of medical wearable technology, patients are able to feed data to PCPs like never before. However, PCPs must have the ability and capacity to incorporate this information in a meaningful manner. How people, process, and technology interface is an area of intense interest and study as the health system attempts to improve strategies and tactics for population health management.

Accessibility Extended

Many PCPs feel helpless when areas of need are identified by an assessment, yet it is unclear how to help address these needs comprehensively. After performing a screening, PCPs need a place for referral to services; this is the role that CBOs and partnerships with community organizations can fulfill. Accessibility also extends to the home and daily life of an older adult. For the frail older adult with multiple chronic conditions and mobility challenges, accessibility likely extends to home visits and home assessments. This may include primary care visits, occupational therapy and safety assessments of the home as well as use of home monitoring devices. Home-based palliative and hospice care, as well as caregiver support and training, are additional extensions of accessibility for older adults. PCMHs should develop approaches to support home-based programs as the Centers for Medicare and Medicaid Services Independence at Home Demonstration pilot program has demonstrated success in costs savings (CMS, 2015).

Health coaches are another extension of accessibility. Serving as a patient facilitator and advocate in a caregiver role, health coaches ensure patients in their home setting, especially those without an advocate, can overcome barriers. Federally Qualified Health Centers are beginning to employ health coaches, especially in communities with social determinant challenges.

Accessibility extends into the community from the PCMH. If skilled or custodial issues are identified by the PCP, such as skilled nursing care, transportation, meals, personal care needs, or caregiver support, community partners should be able to help meet these needs. This applies not only to LTSS, but also involves transitions

of care out of the hospital, into skilled nursing facilities, and back to the home. A PCMH can help an older adult identify and understand needs and ensure these needs are met upon transitions in care. The PCMH and community partners should have a role in ensuring all needs are met, resulting in quality outcomes.

RECOMMENDATION

Active steps a clinic may consider in enhancing accessibility for older adults include:

1. Shorten waiting times, offer around-the-clock telephone access, and/or lengthen office hours.
 2. Facilitate ease of access for family members and other caregivers regarding the number of repeat and return visits for an older patient.
 3. Schedule length of visit to allow time for assessment, education, discussion, and treatment.
 4. Modify the physical space of the clinic for its ease of use by older adults.
 5. Simplify telephone systems with one point of contact, and include family and caregivers in phone communications.
 6. Use convenient technologies, such as e-visits and patient-facing EHR portals as well as extensions of accessibility, such as home visits, health coaches, and home monitoring.
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COMMITMENT TO QUALITY AND SAFETY

Quality and safety improvement strategies are the hallmarks of the PCMH and must be supported by effective organizational leadership. A PCP cannot effectively deliver on the other components of a PCMH model if it does not first address patient safety and care quality. Patients and the PCP may view quality and safety differently. Patients tend to view safety as “doing no harm,” while providers tend to operationalize quality as adherence to medical protocols. Quality, safe health care is a concept intertwined with many other PCMH concepts. For example, good quality care is care that is coordinated among providers, continuous, comprehensive, and patient-centered. Patient engagement is also a key dimension of quality.

Defining the Problem

The United States spends more per capita than any other industrialized nation in the world on health care, and, as such, many Americans assume their country has the best health care; unfortunately, this is not true. The United States experiences high-cost, low-quality care and disparities in care among racial and socioeconomic groups. As many as 91,000 Americans die each year because they do not receive the right evidence-based care for chronic conditions such as high blood pressure, diabetes, and heart disease (NCQA, n.d.b). Quality problems fall into three broad categories according to the National Committee for Quality Assurance (n.d.b), including: underuse (not obtaining medically necessary care); misuse (the wrong care, including injuries); and overuse (unneeded care or too-costly care). Poor quality health care can lead to injury, harm, or death.

Lens on Quality

Viewed through the lens of caring for older adults, quality care means care based on a patient-directed care plan. Quality may be defined with the population of older adults to reflect individual goals rather than quality metrics. An excessive devotion to quality metrics can harm patients in this population and be counterproductive. PCPs might think through how to make decisions with this population by identifying what patients want. Functionality and social elements may be key considerations for an older adult that are not elicited without a full conversation. Assessing Care of Vulnerable Elders (ACOVE) is a useful standard for quality for older adults (Rand Health, n.d.).

ACOVE 3

The Assessing Care of Vulnerable Elders (ACOVE) project developed a short questionnaire to identify and evaluate non-institutionalized vulnerable elders’ medical care needs. The ACOVE 3 measurement set can be used to evaluate the care provided to vulnerable older persons at the level of the health system, health plan, or medical group.

<http://www.rand.org/health/projects/acove/acove3.html>

In a care context for older adults, care planning should usually include PCMH team staff, the patient, caretakers, and family—not only the patient. Care planning should focus on optimal patient-centered outcomes rather than strict adherence to quality measures. Self-management support should be embraced by health systems, community organizations, and government services to ensure fullest possible understanding of care for patients and their families and caretakers and encourage the best possible health outcomes.

Quality improvement efforts include the use of shared decision making with patients and their families as well as responding to patient satisfaction data (RWJF & Aligning Forces for Quality, 2013). Using research evidence as a guide for care will help prevent overtreatment. In shared decision making, a patient’s values and preferences are central factors in choosing among two or more treatment options. Shared decision making will tend to lead to greater patient satisfaction and greater patient understanding of care plans. Good conversation starters (among the many tools and resources available) might be simply: “What do you want to do with your last good years?” or “What is a good day for you?”

However, PCPs must have the time, or be able to schedule the time, to explore options with a patient though shared decision making and an assessment of values and goals. Older patients may have more intensive resource needs in general, such as time and equipment, for safety and quality. Older patients may need more time to move through hallways to minimize falls. Other considerations include special chairs and tables, sufficient lighting, and large-print reading materials. Older adults may have difficulty hearing. To provide

quality care, PCPs should consider whether the physical environment is conducive to treating older adults.

Health Literacy

With older adults, PCPs should be mindful of patient literacy and education on health options. PCPs may serve as an educational resource and should assess the ability of a patient to absorb and address information about health challenges. How health confident is the patient to manage his or her conditions? Patient confidence level and health efficacy are important considerations for quality with older adults. Not all patients can serve successfully in a self-management role, even with the help of family and caregivers. PCPs should be cognizant of the high level of difficulty that confronting a physician presents. An easy way to assess how effective a person is in managing his or her health care is by measuring the person's health confidence level. Health confidence is an effective proxy for an individual's engagement in their care. Wasson and Coleman (2014) have reported on using a simple question to measure health confidence: "How confident are you that you can control and manage most of your health problems?" Patients rate their confidence on a scale from 0 (not very confident) to 10 (very confident), with a score of 7 or higher being the desired response.

Helping patients engage in and understand their care and the variety of medical options, especially for older adults and families and caretakers, is important to ensure quality care is delivered. Plain language training, the use of translators, and training on shared decision making can ameliorate the differences in vocabulary around safety and quality experienced by providers and patients. Efforts to improve health literacy through education will help ensure that patients follow through with medical treatment. Patient decision aids, such as pamphlets, DVDs, websites, and videos, can educate patients and provide condition-specific information about treatment options; decision aids are a component of shared decision making (RWJF & Aligning Forces for Quality, 2013). Additionally, patient engagement through self-management programs has been shown to improve adherence and improve communication with providers. As mentioned earlier in the Comprehensive Care section, evidence-based self-management programs allow individuals to enhance their health by becoming activated and health confident.

Diabetes Prevention Program Likely to become Medicare Benefit

The National Diabetes Prevention Program (DPP), a Centers for Disease Control and Prevention-recognized lifestyle change program, is likely to become a Medicare benefit. Notably, this is the first time that a preventive service model from the CMS Innovation Center has become eligible for expansion into the Medicare program. The program is an in person or online structured program for people who have prediabetes or are at risk for type 2 diabetes.

<http://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html>

Understanding Goals, Values, and Preferences for Care

The process of care planning should always begin with a greater understanding of the health-related values that form the foundation of older adults' treatment goals and preferences for care. Values for health and health care arise from a diverse set of valued life activity and ability domains including (Naik, Martin, Moye, & Karel, 2016):

- **Functioning:** Having or desiring the capacity to care for oneself and functioning in one's daily life. This is often coupled with a sense of independence but many will accept assistance if it enhances overall functioning.
- **Health:** Balancing of one's desire for quality of life with prolonging length of life when evaluating illness and treatment options.
- **Connection:** Expressing feelings regarding the importance of social and spiritual relationships in one's life. Conveying how one wants to be understood or remembered by the important people in one's life.
- **Life enjoyment:** Maintaining or desiring a meaningful sense of physical or emotional well-being; activities associated with enjoyment or meaning of one's life.
- **Engagement:** Acknowledging sentiments and preferences concerning the extent an individual person and his or her family participate in health care decisions and treatment self-care.

Eliciting these health values can be achieved simply through conversations that attempt to understand what is most important in life to an individual. Conversation prompts include:

- “I’d like to talk to you about what you value most in life. Our discussion will help guide all of us—you, your family members, and your health care team—in making health care decisions in the coming weeks, months, and years.”
- “How do your health conditions or treatments affect your ability to be independent? Are there any abilities that are so important to your life that you can’t imagine living without them?” (Bernacki & Block, 2014)
- “If you become sicker, how much are you willing to go through for the possibility of gaining more time?” (Bernacki & Block, 2014)
- “People have different preferences for how much help or support they’d like in making health care decisions. How much do you want your family and loved ones involved in helping to make decisions about your health care?”

Conversations that promote an understanding of adults’ valued life activities and abilities provide a foundation for a more patient-centered approach to health care. For older adults, care based on one’s values and goals contrasts with care driven by performance measures for single diseases or conditions. In situations of multiple chronic conditions—increasingly the norm for older adults—measuring health outcomes using traditional, single disease measures can be overwhelming and costly for health care providers and potentially harmful for patients (Tinetti & Fried, 2004; Casalino et al., 2016).

An alternative approach to assessing the quality of care for older adults with multiple morbidities is to elicit their health care goals and measure their goal attainment *over time*. Quality measurement begins with measuring if and how goals are elicited. Evidence suggests that goal attainment is best predicted by the characteristics of the underlying goals statements. Stated simply, well-crafted goal statements are among the best predictors of goal attainment (Teal, Haidet, Balasubramanyam, Rodriguez, & Naik, 2012). Family members can serve as surrogates for frail or impaired adults by engaging with health care providers to set effective health and health care goals (Bogardus et

al., 2004). Measurement of goal setting and goal attainment are a positive alternative for current approaches to health care quality measurement and assessment, especially since the goals of older adults may not correspond to typical quality measures.

Lens on Safety

Overtreatment and unnecessary medical interventions that may hurt rather than help the older patient are major safety issues (Reilly & Evans, 2009). PCPs should be sensitive to changing one part of an older patient’s treatment plan, because it may affect other aspects of health. Surgery or additional medication may not be in line with older adults’ care plans. As older adults are more likely to be complex and have multiple chronic conditions, medication management is important for the safety of this population. PCPs have a key role to play medication management and polypharmacy. Research has clearly established a strong relationship between polypharmacy and negative clinical consequences (Maher, Hanlon, & Hajjar, 2007).

To illustrate the real-world problems of safety, polypharmacy, and care coordination, Barbara, an independent living resident, shared her story (M. Bolon, personal communication, May 10, 2016). Barbara was admitted to a skilled nursing facility for rehabilitation after a hip replacement. Upon discharge, she was understandably very confused about the ways in which her medication list had expanded prior to her surgery. Barbara said of this experience, “I was on 18 different pills, all from different doctors. I’m very sharp, but I couldn’t keep track. I felt lost and confused. Working with the nurse for a month, we got it down from 18 medications to 9. I felt like—there’s no continuity here. Are they really paying attention?” Barbara worked alongside her PCP and an MA/“med coach” to get organized and eliminate unnecessary medications, and she has returned to managing her own medications independently.

Under-treatment is another major issue for older adults. PCPs should avoid making assumptions about a patient’s personal preferences in treatment because of his or her age. Instead, PCPs should engage in a full discussion of treatment options, no matter a person’s age. A special consideration for older adults is pain management. Palliative care is important to discuss with older adults; to provide good quality care, PCPs should listen to the patient’s desires and goals. The

goal elicitation process can help PCPs identify needs in both treatment and palliative care. Older adults and their caregivers may not feel empowered to ask about procedures and tests; the onus is on the PCP to initiate these discussions.

Care transitions are another issue for PCPs to closely track for older, complex patients. PCPs should put systems in place to attain awareness of a hospitalization and take appropriate steps to follow up promptly after discharge. After an acute episode, PCPs and family members or caregivers may want to change the living circumstances or the daily support provided to an older adult. Rather than make major changes, the PCP should advocate for a geriatric assessment or a primary care assessment; perhaps circumstances can be slightly changed instead of drastically overhauled to meet a patients' needs and care plan while minimizing risk (Elsawy & Higgins, 2011).

Although risk may not be completely removed, the desires of older adults should be balanced against risks. When treating older adults, there is an inherent tension between issues of autonomy and paternalism/beneficence with safety often being the standard used for decisions. For older adults, safe may mean "appropriate" care, rather than care that removes any and all risk, including risk in living circumstances. Older adults and caregivers must assess the actual capacity for independence and autonomy; oftentimes, some level of risk is acceptable to preserve autonomy if that is the individual's goal. To be proactive, the PCP should both develop a care plan for acute episodes and engage in conversations about acute episodes before they occur. PCPs can view this as an opportunity for an expanded advance care planning.

Use of HIT for Safety and Quality

The management of information is essential to good quality care. Using HIT gives providers the information needed, such as complete patient history and medications, with feedback, alerts, and reminders in real time. HIT also allows PCMH teams to complete computerized order entry and charting, case management, and population management. This is important especially for older adults with complex medical needs because tracking multiple conditions can be challenging. HIT encourages better care management and management of information. Other tools, such as in-home assessments, patient portals, e-health visits to PCPs, and telephone and email management, hold promise in improving care quality by providing care at critical moments, as noted earlier in the Accessible Services section. Complex patients, including many older adults, tend to require enhanced access and place additional burdens on a PCMH's resources, both time and staff (Rich & O'Malley, 2015). HIT can help ameliorate care access for older adults with enhanced needs. Finally, HIT can help with health and safety outside of the clinic. Wearable technology, medical alert systems, nutrition monitoring, and home monitoring devices can alert PCPs and family or caregivers about patient needs and enhance care timelines, and thus safety and quality.

Patient Safety Culture

The Agency for Healthcare Research and Quality sponsored the development of the Medical Office Survey on Patient Safety Culture. This survey is designed specifically for outpatient medical office providers and staff and asks for their opinions about the culture of patient safety and health care quality in their medical offices.

<http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/medical-office/index.html>

RECOMMENDATIONS

Active steps a clinic may consider in enhancing quality and safe care include:

1. Define quality through a patient-directed care plan rather than quality metrics. Include family and caregivers as appropriate in developing care plans.
 2. Use shared decision making in choosing treatment with regard for a patient's preferences and values at the center.
 3. Serve as an educational resource for older adults and their family and caregivers while assessing for health confidence. Encourage participation in self-management programs.
 4. Initiate conversations to understand goals, values, and preferences for care to enhance patient-centeredness. Engage in full discussions of treatment options, no matter a person's age.
 5. Use assessments to gauge the acceptable level of support for an older adult; a change in living circumstances may not be necessary. Balance risk and paternalism/beneficence for decisions affecting patient autonomy in daily life.
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Cross-Cutting Issues: Special Considerations for an Aging Population

BECOMING A PCMH TEAM FOR OLDER ADULTS

While our current health care system is improving in the management of chronic disease, it is woefully unprepared and poorly trained in the management of the fundamental needs in primary care for older adult patients. The system of medical training inadequately prepares future and existing care providers across all disciplines—physicians, nurses, social workers, personal care aids—to care for older adults.

Moreover, the number of providers trained in geriatrics is not keeping pace with the need as the size of the aging population rises. A general challenge facing health clinics and the health care system is the significant shortage of providers with specialized training in geriatrics, dementia care, and chronic disease management. The American Geriatrics Society projects that by 2030, there will be only one geriatrician for every 4,484 Americans aged 75 years and older (The American Geriatrics Society, n.d.). In 2012, there were 7,356 certified geriatricians in the United States, but at least 20,000 geriatricians are needed to effectively serve the population aged 85 years and older (Brittain, 2013). Geriatric training helps providers develop the necessary skills for developing realistic care plans and balancing quality metrics with patients' individual life goals. Other important components of a PCP who is sensitive to the needs of older adults include taking a whole-patient view, rather than focusing on a diagnosis, and initiating conversations about end-of-life planning.

The Eldercare Workforce Alliance

The Eldercare Workforce Alliance is a group of 31 national organizations joined together to address the immediate and future workforce crisis in caring for an aging America.

<http://www.eldercareworkforce.org/about-us/who-we-are/>

The Geriatrics Workforce Enhancement Program

More than \$35 million in awards will go to 44 organizations in 29 states to support quality care for older Americans through the Geriatrics Workforce Enhancement Program funded by the U.S. Department of Health and Human Services. The Geriatrics Workforce Enhancement Program aims to improve the quality of health care for older Americans by:

- Changing clinical training environments into integrated geriatrics and primary care delivery systems.
- Training providers who can assess and address the needs of older adults and their families or caregivers at the individual, community, and population levels.
- Delivering community-based programs that will provide patients, families, and caregivers with the knowledge and skills to improve health outcomes and the quality of care for older adults.

http://www.hrsa.gov/about/news/pressreleases/150713_geriatricworkforce.html

The 2008 Institute of Medicine report *Retooling for an Aging America: Building the Health Care Workforce* highlights significant challenges with recruitment and retention of all geriatric specialists (National Academies of Sciences, Engineering, and Medicine, 2008). The high cost of training, coupled with lower pay than other specialties, a lack of opportunity for more advanced training, and ageism are all factors in decreasing rates of geriatric specialists. This includes medical providers, such as psychiatrists, nurses, social workers, pharmacists, mental health workers, and community workers. Retention is a particular challenge with direct care workers, such as home health aides, social workers, and certified nursing assistants, whose jobs are extremely important for older adults aging safely in the community or in a facility. These positions

often are considered undesirable because of low pay, lack of job stability or security, poor working conditions, high rates of on-the-job injury, and few opportunities for advanced training. Another significant challenge for the direct care workforce development is a lack of rigorous federal and state minimum training requirements to ensure competency and ability to care for older adults.

Opportunity to Build the Workforce

Rather than despair and call for incentives to change medical education, PCPs should endeavor to build the direct care workforce for providing geriatric-competent care through training and education. The community health workforce already in place needs proper training to respond to the already-growing needs of the population of older adults. PCMH teams and the community health workforce need more exposure, experience, and cross-training to build on their existing skill sets through continuous training. Teams with cross-training will be able to operate outside their normal scope and change workflows. The PCMH team should be connected through HIT to effectively respond to the needs of the older adult population.

One possible strategy to address the insufficient workforce is enhancement of team-based care. Sharing various parts of a patient's care with other capable team members not only maximizes use of each member's particular skill set, but frees up time for PCPs to interface with their patients at the right time and for the right reasons. For example, many chronic conditions can be co-managed with a clinical pharmacist or behavioral health professional, allowing PCPs more time to focus on comprehensive assessment and goal setting as well as increasing their availability to address acute needs.

Another workforce strategy is to further develop the "medical neighborhood" concept. The medical neighborhood is defined by the Patient-Centered Primary Care Collaborative as "a clinical-community partnership that includes the medical and social supports necessary to enhance health, with the PCMH serving as the patient's primary 'hub' and coordinator of health care delivery" (PCPCC, 2015b). The medical neighborhood occurs when a high-functioning PCMH is able to successfully connect with patients, specialists, hospitals, home health, long-term care, and non-clinical community partners. The Agency

for Healthcare Research and Quality states that a medical neighborhood will “focus on meeting the needs of the individual patient but also incorporate aspects of population health and overall community health needs (Taylor, Lake, Nysenbaum, Peterson, & Meyers, 2011).” As such, PCPs should devote time to identifying community partners, fostering relationships, and building them to last to support older adults. Technology can play an essential role in communicating among partners about the needs of complex patients.

Importantly, these approaches will have to show the value that these changes will have on care delivery and demonstrate that they can be replicable and financially sustainable. The return on investment of building a direct care workforce will be realized through greater satisfaction of physicians, nurses, social workers, the direct care workforce, and all involved in the care of an older patient. If the PCMH team members have the training, expertise, and support to successfully care for the older adult population, their job satisfaction will translate into retention and cost savings for the PCMH. Increased job satisfaction will make the care of older adults more positive and pleasant and thereby result in less job turnover.

The majority of the health workforce will be working with older adults and patients with issues of medical complexity and frailty, even those who do not elect to specialize in geriatrics. For instance, 73 percent of social workers provided services to older adults in 2007, but only 9 percent considered their practice area to be “aging.” It is thus critical that the general health care workforce receives training that recognizes the important roles of primary care, home- and community-based services, and mental health supports to truly move toward whole-person care across the spectrum (National Association of Social Workers, 2008).

Private and community foundations across the country are recognizing the strategic impact they can have by supporting geriatric workforce development. For example, the Donald W. Reynolds Foundation has supported medical schools in strengthening their geriatrics training for medical students, residents, and practicing physicians (Reuben et al., 2009). Through these efforts, geriatrics became better integrated structurally, procedurally, and clinically into the curriculum, rotations, and continuing education. A

significant result from these efforts is that students at these institutions report feeling better prepared to care for older adults than students at other schools without the funding.

The Dementia Caregiving Network

The Dementia Caregiving Network through The John A. Hartford Foundation Change AGENTS Initiative focuses on the needs of the caregiver with resources identified to improve the care delivered. The goal is to improve the lives of caregivers as they go about the daily tasks of caring for a family member with dementia.

<http://www.changeagents365.org/change-agents-networks/dementia-caregiving>

Moving forward, it is critical that the government, advocates, philanthropic community, and academic institutions continue to address these workforce challenges through innovative training programs and improved reimbursement for geriatric and direct care services. At the same time, PCMH teams should endeavor to provide training in caring for older adults to their existing workforces and build relationships to CBOs.

FINANCING, PAYMENT, AND THE BUSINESS CASE

Springfield Family Medicine is a medium-sized practice that prides itself on its integrity and focus on patients and their needs. As new opportunities for payments have arisen, it has embraced this set of changes. In the past four years, the clinic has worked actively with its coordinated care organization (managed care for Medicaid), expanded its Medicaid population, and inserted providers into behavioral health organizations; the clinic also participates in the Comprehensive Primary Care initiative and Area Agencies on Aging. In order to meet requirements, the clinic has expanded its primary care team with care managers, panel managers, a part-time clinical pharmacist, and behaviorists; beyond the costs of its standard EHR, the clinic pays tens of thousands of dollars for additional reporting and has negotiated with local hospitals to receive an additional admission, discharge, and transfer fee. For all this, the clinic's annual revenue from fee-for-service is 80 percent.

Many primary care practices are making similar efforts, but have not seen sustainable payment arrangements needed to support them. Historically, fee-for-service favors procedures for reimbursement, and cognitive processes—difficult to translate into a relative value system focused on concrete inputs—are undervalued. With increasing cost pressures from the transformation required by the PCMH and other initiatives, practices face tough decisions on how to obtain the revenue to stay afloat. Some opt out completely—joining staff model health systems or becoming concierge or direct primary care practices that require direct patient payment outside of or in addition to insurance. Others have chosen to integrate into independent practice associations in order to more effectively negotiate and share resources. With the pledge of U.S. Department of Health and Human Services Secretary Sylvia Burwell, the majority of CMS payments will be value based by 2018. Independent practices must learn to transform or risk future insolvency (U.S. Department of Health and Human Services, 2015).

In exploring how PCMH practice transformation aligns with payment, we find that the care of older adults offers an exceptional opportunity to demonstrate higher value. How can a focus on the needs of older adults improve a primary care practice's success in

leveraging its PCMH status to improve care? And, how can individual PCMHs gain access to the savings that they can generate? The following discussion takes a closer look at these issues.

The Value Proposition

Systemic conversion of primary care to the PCMH model requires the development of business models that are both acceptable to payers and sustainable for PCPs. Practices employ additional staff, incur ongoing costs related to technology, and must shift attention away from activities that are currently better compensated. Therefore, the cost of primary care in the PCMH, and the reimbursement required to support it, will be higher than that of the under-resourced setting of primary care it will replace.

Although primary care practices generally do not have the power to change the reimbursement system, they can decide to both participate in PCMH payment redesign programs and choose how they implement the programs to achieve the best financial impact. Practices might choose the PCMH and how focusing on needs of older adults should help them meet expectations, as discussed below. Value, here, is the benefit over the cost, and investment in primary care has the promise of significant value to older adults and the broader health system.

From a finance perspective, the primary reason to transition to the PCMH model at this time is that PCPs need to prepare for the future; as the U.S. Department of Health and Human Services has promised, payment will transition to value-based care, and PCMHs are well-positioned to show value. There is financial risk, however, involved in implementing the PCMH, especially for PCPs who are not in a large health system. PCPs usually operate on thin financial margins, and PCMH conversion involves hiring additional staff and devoting additional financial resources. Research has been mixed to date on the value proposition of the PCMH to PCPs.

Despite the financial risk, employers increasingly want to pay for value-based care that demonstrates a population is using less care and/or driving more value from the care it receives. Given the complexity of the health of older adults, a larger subset of older adults are high cost, high need, and costs are highly

concentrated for these patients. For example, 5 percent of the most complex population often drives 50 percent of payments. If PCMH practices can help to improve health and well-being for these patients, their entire medical costs can be decreased and a cost savings may be achieved. PCPs can then leverage some of this savings if, in the future, they are paid on the basis of value. If PCMHs have a positive return on investment, then they can use those savings to pay for additional team members and/or ask payers to financially reward their costs savings.

Policy Change

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law. MACRA will provide payment incentives through advanced Alternative Payment Models (APM) which total 5 percent of their Medicare pay (CMS, n.d.); one such medical home model, the Comprehensive Primary Care Plus initiative, has been selected as an APM and other PCMH models are likely to be selected. This represents a substantial incentive to PCPs, which have the capacity to unlock enormous savings in the health care system. MACRA enables advanced PCMHs to employ APMs without having to put themselves at risk of financial loss (Nielsen, Buelt, Patel, & Nichols, 2016). Accountable care organizations require excellent primary care to avoid unnecessary utilization and costs for patients with complex conditions, and may pay incentives directly to PCMHs; alternatively, advanced APMs like the proposed Comprehensive Primary Care Plus initiative would pay an average of \$28 and maximum of \$100 per member per month to PCMHs with incentives directed at individuals, especially older adults, with complex conditions such as dementia.

Specific Components of PCMHs Addressing the Needs of Older Adults and Return on Investment

Return on investment in health care can mean additional value for changing payment or cost reductions. Both are possible for PCMHs focused on older adults. PCMHs promote the development of team approaches, which will broaden the scope of care to include considerations of function and patient self-management. Older adults are more likely to need a diverse team, with increased frailty leading to more needed input from social workers, pharmacists, and nurses. Highly coordinated care delivered by a team is a key PCMH attribute; such care has been shown to

improve value through better quality and lower costs in a variety of settings (Nielsen, Buelt, Patel, & Nichols, 2016). By focusing on providing more team-based care management and care coordination, practices may reduce hospitalizations, reduce nursing home stays, and avoid complications common in older adults, such as hip fractures and urinary tract infections.

The Payoff

Payments to PCPs account for only a small percentage of total health care spending—approximately 5 percent. However, PCPs exercise great influence on downstream spending through their decisions and referrals. It is the ability of better primary care to contain spending overall that provides the cost-saving opportunity of the PCMH approach. Most expensive care occurs outside of the PCMH; the market environment surrounding the PCMH can help or hinder its performance. By focusing care on complex older adults, PCMHs can help new value-based payment systems such as advanced APMs achieve better care at lower costs.

EHRs AND THE CARE OF OLDER ADULTS WITH COMPLEX AND MULTIPLE MORBIDITIES

In the care of complex and multi-morbid older adults, traditional approaches to medical record charting have limitations. Despite offering the promise of enhanced functionality and flexibility, EHR systems have not alleviated these limitations. Traditional medical records are written in a first-person narrative style by single authors. In many cases, this is a clinician or other health care provider offering services (health and social care) to the patient. For complex older adults with multiple health care providers, there may often be several clinicians writing notes regarding the patient's care (even for the same clinical condition). Provider's notes, unfortunately, are not integrated or coordinated by every provider all the time because of this note-taking convention. EHRs offer the ability to cut-and-paste text from another provider's notes—an improvement—but this does not necessarily mean that each provider fully absorbs, integrates, and comments on previous providers' notes about a patient. Keep in mind that HIT is a means to an end—to serve the patient and care team.

Care of Older Adults and EHRs

First and foremost, care should be oriented around patient-defined health and life goals for older adults, as previously discussed, rather than providers' goals or endpoints. This orientation would not ignore or counter evidence-based guidelines or treatments grounded in scientific advances. Instead, it would allow clinicians to think and work creatively on how to best align evidence-based treatments with patient-driven goals (instead of disease-based guidelines alone). In this paradigm, patient-defined goals are available at the center of every EHR note, prominently featured, rather than on the periphery of the notes structure. For example, patient goals would be the headliner of the provider's assessment (in the Assessment and Plan sections of the note) and treatment plans would be aligned with and organized by patient goals rather than solely by diseases or organ systems.

Second, EHR innovations would allow for asynchronous and real-time coordination of care among different health care providers working together on the same patient and perhaps even concerning the same condition. One possible option would be a more wiki-style of notation—that is, a web-

based place for collaborative editing—according to the patient or a condition. Future innovations in EHRs need to better capture the asynchronous, coordinated, and inter-professional nature of health care teams that care for older adults with complex and multiple morbid conditions.

Third, the inclusion of patients, patient surrogates, and involved caregivers and family members is essential for effective care of complex older adults. Recent innovations such as “open notes” and patient health portals are early examples of how patients and their families and caregivers can be better integrated into the health care team and access personal medical information securely. OpenNotes (n.d.) is an online system that gives patients access to the visit notes written by their providers.

Fourth, greater communication and integration among primary and specialty care physicians as well as health care professionals in outpatient, home care, hospital, long-term care, and transitional care facilities is needed. EHRs hold the promise of greater coordination, but most do not allow interoperability among such a diverse set of providers. EHR vendors and health care systems need to ensure mechanisms for communication among providers who must coordinate care for older, multi-morbid adults across care settings.

Finally, other technological advances can enhance the care of older adults. Technologies such as wearables, home monitoring of function and activity, and communications technology can all enhance coordination and self-care. For example, a central home monitor tied to personal wearable devices (such as a watch) can measure the mobility and functional status of an at-risk older adult. If the home monitoring system notes a significant decline in mobility or daily activity, it can send a message or alert to the older adult and designated family members. For example, Bob, an 83-year-old widower who lives alone and recently has been having trouble with his activities of daily living, can have a new home monitoring system set up to alert his son and PCP's office if it notices two standard deviations or more declines in functioning over three consecutive days compared with normal levels. This early prompting of diminishing

function could promote an early check-in on Bob and potentially some pre-emptive treatment if he is experiencing illness symptoms.

Getting the Patient's Voice into the EHR—Patient Response

Patient-centered care is impossible without bringing the patient's voice into the EHR. Too often, medical care is a one-way trip: from doctor to patient. Too often, care teams provide health education support, care plans, and care goals to patients without first asking what is important to the patient or what the patient's goals are. And, even if a clinician has taken the time to have conversations about the patient's goals, others on the care team have no visibility into the patient's point of view or what the patient values. Building in a capacity for patient response solves this problem.

The exemplar case of a hypothetical patient, Jo, with hip arthritis shows how patient response works:

Step 1: Jo meets with her physician who diagnoses osteoarthritis in Jo's right hip. When he enters the diagnostic code in Jo's EHR, the physician sees a drop-down list of patient education materials. These will help Jo obtain a deeper understanding of her condition and treatment options. As easily as he might order a lab test or prescription, the physician just clicks to order a video and a shared decision aid for Jo. The prescribed patient education materials are delivered electronically to Jo's patient portal (the patient-facing part of Jo's EHR).

Step 2: Jo receives an email or text invitation to go to her patient portal and open the information prescription of the video and patient decision aid from her physician. Jo watches the educational video and answers a few questions at the end, which gauge her level of understanding of the information. Her responses go back, electronically, into her health record. Jo next opens the patient decision aid for people who are considering a hip replacement. Step by step, she is guided through the risks and benefits, and pros and cons, of the procedure backed by the evidence as it applies to her and her hip. Jo enters her response, indicating her concerns, priorities, and preferences, into the EHR.

Step 3: Jo's clinical care team now can align Jo's care plan with her preferences, concerns, and values. Her team can see and answer her questions. Her care plan is tailored to who she is. Her patient-directed goals are clearly on view for the entire care team. Jo's preferences help guide the next steps she and her team will pursue in the treatment of her hip pain.

Patient and providers working as a team create the core of patient-centered care—notably, the patient's voice must be heard. Two-way, interactive patient portals, such as My Care, allow providers to share information securely, provide educational information digitally, and improve communication with patients. With such patient portals, patients and family can record their thoughts and questions about interventions. Patients and family members can be alerted to certain chosen activities in the patient portal. As this technology becomes more sophisticated for two-way communication, its applicability and usefulness to the PCMH model for older adult care will grow.

HIT and Shared Decision-Making

An area of ongoing research and development efforts will be the testing and implementation of HIT interventions to facilitate shared decision making among older adults, their caregivers, and health care provider teams. Older adults with complex and multiple morbidities will require more deliberate and often highly personalized approaches to care (compared with rapid, guideline, or protocol-driven care). This "minimally disruptive" but personalized approach to treatment planning will benefit from HIT applications that facilitate shared approaches to care. These applications would include user interfaces for family and patients; patient portals for assisting with self-management education, tracking, and support; and tools for values clarification, preference elicitation, goal setting, and alignment of treatments with goals—all instrumental elements of shared decision making for older adults with multiple chronic conditions.



Conclusion: Opportunities in a PCMH Enhanced for Older Adults

The benefits of implementing a PCMH enhanced for older adults are numerous. Primary care is the ideal place to coordinate care because of the long-term relationships formed, health information contained within the primary care practice, and the opportunity to perform assessments and begin care planning conversations. If PCPs are able to provide the best care possible, benefits can expand well beyond the older adult patient. PCPs may access the savings they accrue and satisfaction will increase for all members of the care team. A PCMH enhanced for older adults is also a health care workforce satisfaction and retention issue, and thus a return on investment issue for PCPs. Additionally, as CMS moves the primary care field toward value-based care, PCPs would be wise to begin to transition for future health care financing.

PCMHs and PCPs considering becoming PCMHs have an opportunity to move into the future by shaping their practices to address the particular concerns of older adults. The PCMH for older adults is the optimal model to serve all populations, including older adults with medically complex needs; as the percentage of Americans 65 years of age and older continues to grow due to demographic changes, primary care will be the locus of health care coordination. PCPs are already performing the work of caring for older adults, although perhaps not intentionally. A PCMH enhanced for older adult care will allow PCPs to provide better care for the population they are already serving. Frailty can occur at any time for older adults, and they may move into and out of a frail state over time; the example of Hilde's fall, isolation, and then recovery shows this circumstance. The enhanced PCMH would be equipped to address frailty in older adults seamlessly, as a layer of care. Systemic change to enhance comprehensive, accessible, quality, safe, and coordinated health care will benefit not only the most complex and most frail patients, but the entire population of patients. Older adults comprise a population that matters and great strides can be made in their care and well-being. As a

moral imperative, older patients deserve respect and quality care that meets their goals. Older adults with well-managed chronic health issues may benefit even further from an enhanced PCMH.

Primary care teams need not be alarmed by the idea of total system overhaul. As discussed in this concept paper, PCPs can begin transformation of the PCMH by training their existing workforce, expanding phone hours, or initiating connection to a local Area Agency on Aging. The work of becoming an enhanced PCMH for older adults may be layered into existing workflows, rather than beginning from scratch or seeing it as an extra to-do list item. The PCP cannot do this work alone. Help already exists and PCPs must access it. Partnering with patients and caregivers is essential and giving them access to evidence methods so that they may become activated and better self-managers of their care is a fundamental part of this change. Connecting to community organizations is crucial for supporting older adults to live independently (and interdependently) as part of a networked web of social and other supports. PCPs need places to refer older adults for their non-medical needs and care that allows for a high quality of daily life. CBOs offer the promise of supportive services that can be chosen under a care plan. CBO-PCP partnerships offer older adults choices about where they live, work, and play. Partnering with CBOs is not a new idea, but it is a new idea to the PCMH model today.

Above all, PCPs should be aware of the values and goals of older patients and design care plans to guide care delivery. PCPs should take the time to properly communicate with patients to elicit their goals and preferences, and incorporate families and caregivers as appropriate. Care plans may deviate from standard quality metrics typical for other patient populations. Individualized care plans take into account both physical and psychological needs, and the true measure of success is quality of life as defined by the older adult. By addressing these essential components of care delivery through a PCMH, older adults, even those with complex needs, will be able to live healthy lives in communities of their choice.

The PCMH Network members present this paper with the hope that it will serve as a call to action to all those PCPs who are transforming the way care is being delivered to our nation's older adults. By engaging in this transformation, the PCMH will help their older adults and their caregivers live with the dignity and independence they want to have in a manner sustainable for our U.S. health care system and all of its stakeholders.

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