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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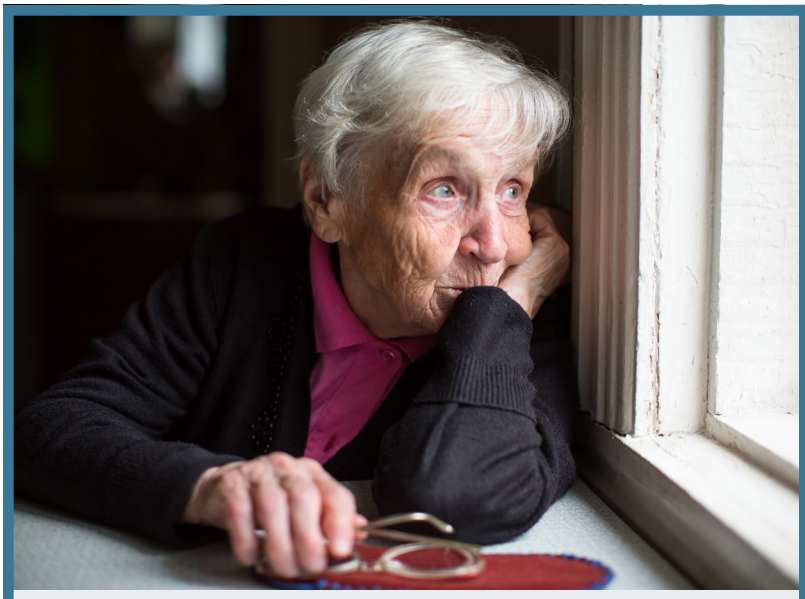
Achieving success as a Patient-Centered Medical Home (PCMH) is a journey. Consumer advocates understand that in order to succeed, PCMHs must address the unique needs of what is often a growing and complex part of the patients they serve—older adults. This new and practical publication from The John A. Hartford Foundation Change AGEnts PCMH Network highlights compelling stories of how PCMHs have transformed outcomes for older adults and offers a roadmap to meeting the challenges PCMHs face, including special considerations for an aging population such as:

- Ensuring primary care coordination across all settings, medication management, and patient involvement in the electronic health record;
- Partnering with community-based organizations to address the non-clinical care issues facing older adults—housing, transportation, food insecurity, and more;
- Engaging consumers and their families in care through consumer advisory councils, care experience surveys and shared decision making, resulting in truly whole-person care;
- Improving outcomes by tying quality measures to patient functioning and quality of life; and
- Understanding how PCMHs can benefit under new federal Medicare payment changes.

Advocates' Checklist for Consumer-Centered PCMHs

1. Use the Medicare Annual Wellness Visit—free to Medicare enrollees—to create a patient-centered care plan.
2. Partner with community organizations, such as Area Agencies on Aging, that provide services and supports to older adults and their families and caregivers to fill gaps in care.
3. Initiate advance care planning conversations to identify goals of care, and update as patients' wishes change over time.
4. Facilitate better transitions of care by establishing and monitoring relationships with specialty care, local hospitals, and long-term care settings.
5. Incorporate home visits and home assessments to meet the accessibility needs of frail patients and those with mobility issues.
6. Provide training and education of all staff in geriatric-competent care models (or practices).



Hilde's Story

Hilde is an active 89-year-old with a robust family, social, and civic life. She manages her diabetes mellitus and hypertension well on her own, but recently fell and broke her wrist. After surgery, Hilde moved in with her daughter, 30 minutes from her own home and social network. She became afraid of falling, stopped exercising, and became increasingly depressed and isolated. Despite receiving medical care, Hilde continued to become more depressed as time went on and her doctor was concerned about her basic functioning. By discussing and documenting Hilde's wishes and goals for her life and her healthcare, and connecting her to community based organizations that could help her maintain her independence at home, the doctor ensured that Hilde could continue to maintain her independence, plan for a time when that wasn't possible, and resume her usual activities. The entire multidisciplinary PCMH team knew Hilde's goals of care and her personal journey, and Hilde knew that the team would be readily available to her if she needed them. Hilde's story illustrates an increasingly important imperative—that with the support of a PCMH, quality of life is possible for older adults, even those facing a setback and multiple chronic conditions.

For More Information

Care Coordination

Patient Priority Care
www.jhartfound.org/blog/tag/care-align/

Caring for Seniors: How Community-Based Organizations Can Help
www.aafp.org/fpm/2014/0900/p13.pdf

Recent examples in effective care coordination:

- ACA/Comprehensive Primary Care Initiative
- Federally Qualified Health Centers (FQHCs)
- VA model of care coordination for veterans with dementia
- Vermont's Support and Services at Home model
- The Bridge Model of transitional care in Illinois

Comprehensive Care

National Council on Aging Toolkit for Physician Champions
www.adrc-tae.acl.gov/tiki-download_file.php?fileId=27090

Alzheimer's Association Annual Wellness Visit Tools
www.alz.org/health-care-professionals/clinical-guidelines-information-tools.asp

Consumer Engagement

Center for Consumer Engagement for Health Innovation
www.healthinnovation.org

Patient-Centered Care

The Conversation Project
Theconversationproject.org

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The John A. Hartford Foundation PCMH Change AGEnts Network is managed by The Gerontological Society of America and funded by The John A. Hartford Foundation.