Comprehensive Primary Care for Older Patients with Multiple Chronic Conditions

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JAMA 2010, Care of the Aging Patient: From Evidence to Action

Ms. N

77 year-old widow

Retired factory worker

Lives alone

Income: Social Security

Insurance: Medicare, Medicaid

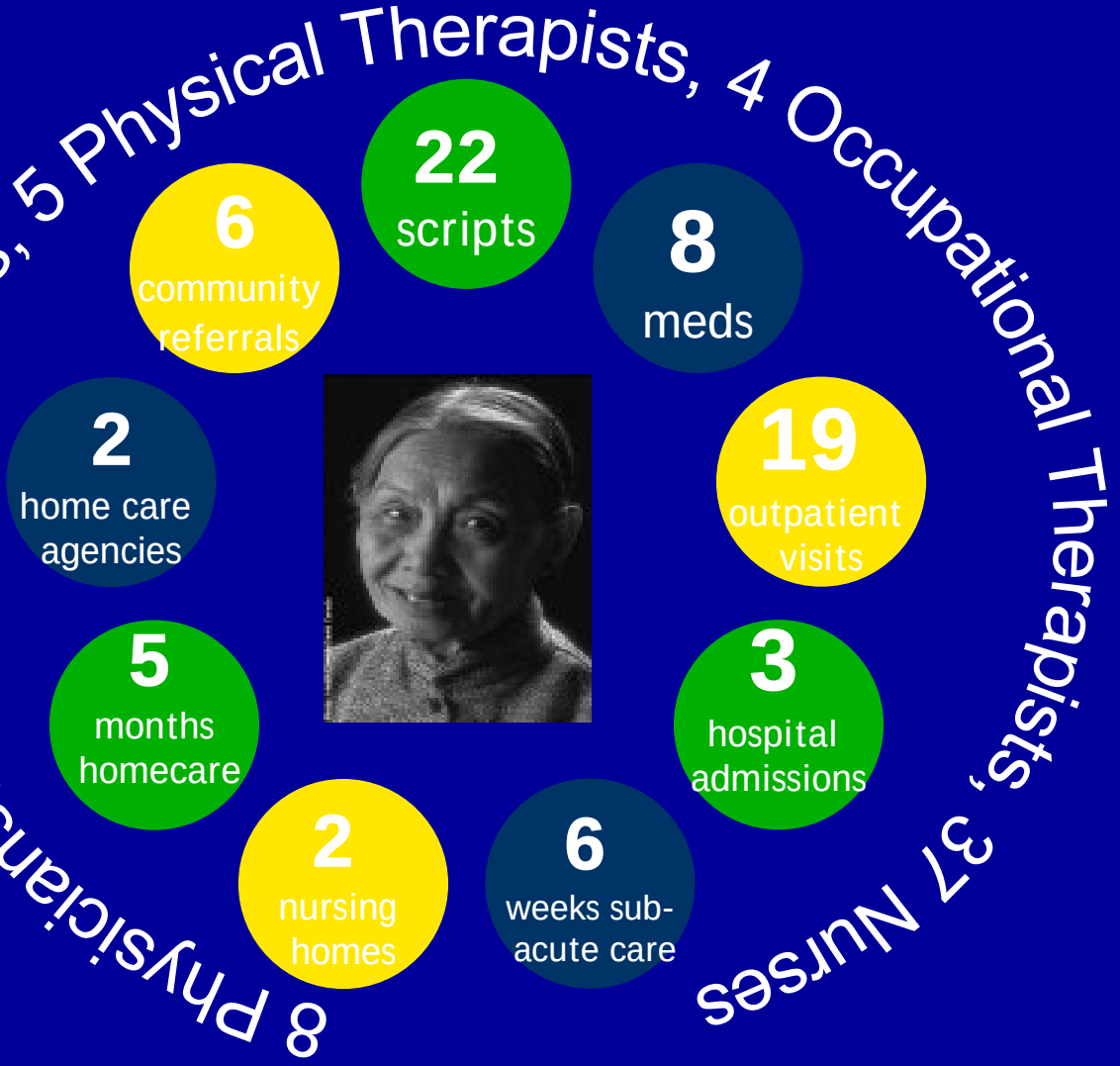
Daughter, lives 10 miles away with husband and three teenagers

Six chronic conditions

Physicians: GIM, ophthalmologist

Eight prescription medications

A year in Ms. N's life



Ms. N

- Confused by care, meds
- Feels discouraged
- Adheres only partially

Daughter

- Stressed out
- Reduced work to half-time
- Considering nursing homes

Medicare paid $42,400 to providers for her care

Infrastructure Deficiencies

Professional education in complex chronic care

Health information technology

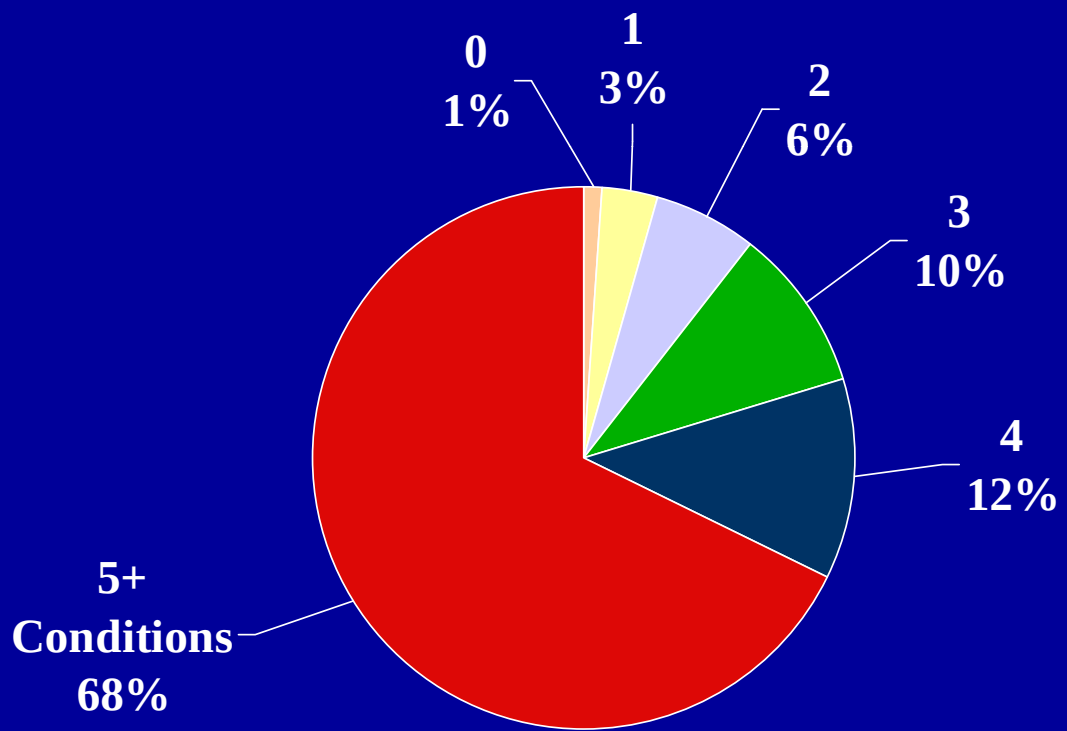
Insurance coverage

Separation of medical and social services

Ms N's care is

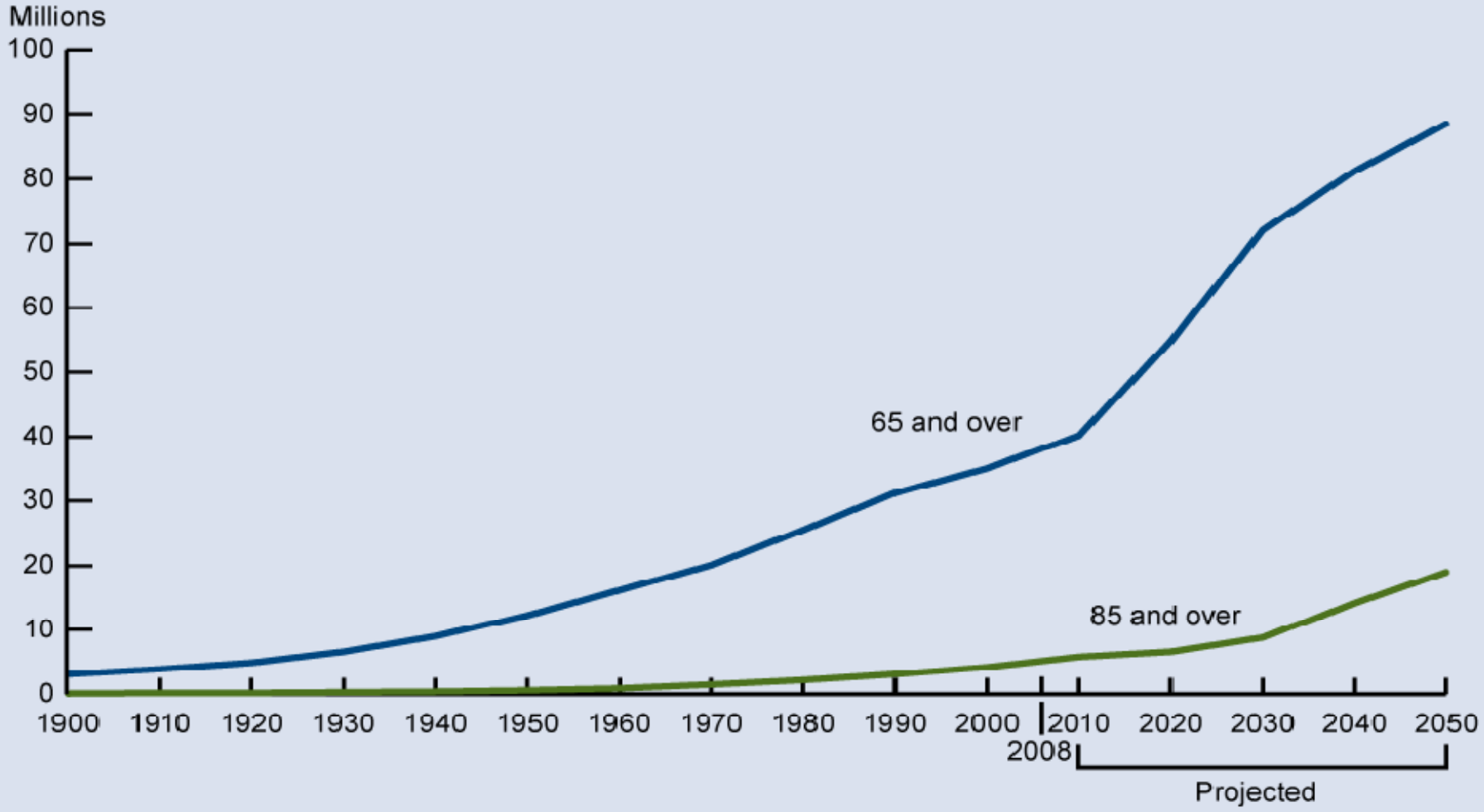
Fragmented
Uncoordinated
Inefficient
Expensive

The ¼ of Beneficiaries Who Have 4+ Chronic Conditions Account for 80% of Medicare Spending



Number of Older Americans

Population age 65 and over and age 85 and over, selected years 1900–2008 and projected 2010–2050



NOTE: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
SOURCE: U.S. Census Bureau, Decennial Census, Population Estimates and Projections.

Costs of 7 Chronic Conditions

In 2003:

Treatment	$0.277 trillion
↓ Productivity	1.100 trillion
Total	$1.377 trillion

In 2023:

Total	$4.2 trillion

"The trajectory we're on is unsustainable"
Dr. Richard Carmona, former U.S. Surgeon General

Summary of Literature

- September 1999 – August 2010
- High-quality studies:
  - Models of comprehensive primary care for patients with multiple chronic conditions
  - Measured quality of care, quality of life, and use/cost of health services
- Four care models identified

Home-based Primary Care

Developed in the VA system

Interdisciplinary team visits patients' homes

Results from a 12-month RCT:

- Greater satisfaction with care by patients and family caregivers
- No difference in functional ability
- Increased total health care costs

Hughes SL et al. *JAMA* 2000;284(22):2877-85

Geriatrics Resources for Assessment and Care of Elders (GRACE)

Primary care physicians work with on-site social worker and advance practice nurse (with consultation from an off-site interdisciplinary team) to provide comprehensive care for low-income seniors.

Results from a 24-month RCT:

- Improved quality of care
- No difference in patients' function or satisfaction
- No difference in hospital admissions or total costs
- Among high-risk pts, 23% lower total costs in Year 3

Counsell SR. *JAMA* 2007;298(22):2623-33
Counsell SR. *J Am Geriatr Soc* 2009;57(8):1420-6

Guided Care

3-4 primary care physicians partner with an on-site registered nurse to provide comprehensive care for 55-60 high-risk patients with multiple chronic conditions.

Results from the first two years of a cRCT:

- Improved quality of care
- Greater physician satisfaction with care
- Trend toward reduced net cost of care (11%)

Boyd CM. *J Gen Intern Med* 2010;25(3):235-42
Marsteller JA. *Ann Fam Med* 2010;8:308-15
Leff B. *Am J Manag Care* 2009;15(8):555-9

Program of All-inclusive Care for the Elderly (PACE)

Interdisciplinary team based at a day health center provides comprehensive care in all settings for disabled "dual eligibles"

Results of 3 cohort studies:

- After 12 months, fewer admissions to hospitals, but more admissions to nursing homes
- After 5 years, longer survival among patients at high risk for dying
- After 6 years, improved quality of care, but no difference in patients' health, function or satisfaction with care

Nadash P. *Gerontologist* 2004;44(5):644-54

Wieland D. *J Gerontol A Biol Sci Med Sci* 2010;65(7):721-6

Beauchamp J. Mathematica Policy Research 2008

Essential Chronic Care Processes

- Comprehensive assessment
- Comprehensive evidence-based planning and proactive monitoring of care
- Coordination of all providers of care
- Promotion of patient engagement in care

Successful Widespread Adoption

- Appeal to all the stakeholders
- Source of initial investment: HIT, training, change in work flow, construction
- Skilled professional labor pool
- Payment for the additional ongoing services
- Incentives to achieve the target outcomes
- Technical assistance: targeting patients, implementing processes
- Astute management of the new models

Grant Support

The SCAN Foundation

The John A. Hartford Foundation

The Agency for Healthcare Research and Quality

The National Institute on Aging

The Jacob and Valeria Langeloth Foundation

Resources

GRACE
www.innovations.ahrq.gov/content.aspx?id=2066

Guided Care
www.GuidedCare.org

PACE
www.npaonline.org/website/article.asp?id=4

Patient-Centered Primary Care Collaborative
www.pcpcc.net/pcpcc-pilot-projects