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

- 22 scripts
- 8 meds
- 19 outpatient visits
- 3 hospital admissions
- 6 weeks sub-acute care
- 2 nursing homes
- 5 months homecare
- 2 home care agencies
- 6 community referrals
- 37 Physicians, 6 Nurses, 6 Social Workers, 5 Physical Therapists, 4 Occupational Therapists
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

- 0 conditions: 1% (1)
- 1 condition: 3% (6)
- 2 conditions: 6% (12)
- 3 conditions: 10% (3)
- 4 conditions: 12% (4)
- 5+ conditions: 68% (68)

Source: Medicare 5% Sample, 2001
NOTE: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
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%)

Marsteller JA. *Ann Fam Med* 2010;8:308-15
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
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