Comprehensive primary care programs treat older patients with chronic conditions

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In a review of comprehensive primary care programs for older adults with multiple chronic conditions, authors identified three models that appear to have the greatest potential for improving quality of care and life for these patients, while reducing or not increasing the costs of their health care, according to an article in the November 3 issue of *JAMA*, a theme issue on aging.

Chad Boult, M.D., M.P.H., M.B.A., of the Johns Hopkins Bloomberg School of Public Health, Baltimore, presented the findings of the study at a *JAMA* media briefing at the National Press Club.

"Older patients with multiple chronic health conditions and complex health care needs often receive care that is fragmented, incomplete, inefficient, and ineffective," write Dr. Boult and co-author G. Darryl Wieland, Ph.D., M.P.H., of Palmetto Health Richland Hospital, Columbia, S.C. To identify models of care that may be more effective, the authors conducted a search of the medical literature for studies regarding U.S. models of comprehensive primary care for older patients with multiple chronic conditions.

The authors write that, based on expert consensus about the available evidence, there are 4 proactive, continuous processes that can substantially improve the primary care of this patient population: comprehensive assessment, evidence-based care planning and monitoring, promotion of patients' and (family caregivers') active engagement in care, and coordination of professionals in care of the

patient—all tailored to the patient's goals and preferences.

Using these criteria, three models of chronic care were identified that include these processes and that appear to improve some aspects of the effectiveness and the efficiency of complex primary care—the Geriatric Resources for Assessment and Care of Elders (GRACE) model, Guided Care, and the Program of All-inclusive Care for the Elderly (PACE).

All 3 models are based on care by teams of health care professionals, including primary care physicians, registered nurses and other health professionals. Teams in all 3 models provide many of the same services to older patients with complex health care needs, including:

- comprehensive assessment
- development of a comprehensive care plan that incorporates evidence-based protocols
- implementation of the plan over time
- proactive monitoring of the patient's clinical status and adherence to the care plan
- coordination of primary care, specialty care, hospitals, emergency departments, skilled nursing facilities, other medical institutions, and community agencies
- facilitation of the patient's transitions from hospitals to post-acute settings and the patient's access to community resources, such as meals programs, handicapped-accessible transportation, adult day care centers, support groups, and exercise programs.

The authors add that these models do have some significant differences in certain aspects of their structures and operations. In the GRACE model, an advance practice nurse and a social worker collaborate with primary care physicians in community health centers to provide comprehensive care for low-income patients. Care is reviewed regularly by an offsite geriatrics interdisciplinary team. In the Guided Care model, 2 to 5 primary care physicians partner with a registered nurse practicing at the same site to provide comprehensive primary care to 55 to 60 older patients who are at high risk for using extensive health services during the following year. Each PACE site operates as a managed care plan that receives capitated payments from Medicare and Medicaid and uses these funds to pay for all of the health-related services required by its patients.

"As the United States implements new models of chronic care, such as the 3 described here, more research is needed to define the optimal methods for identifying the patients who will benefit most, for providing the essential clinical processes, for disseminating and expanding the reach of these models, and for paying for excellent chronic care. Also necessary will be significant advances in the education of health care professionals and the managerial infrastructure that underlies new models of care," the authors write.

In an accompanying commentary in this issue of *JAMA*, Arpita Chattopadhyay, Ph.D., and Andrew B. Bindman, M.D., of San Francisco General Hospital, University of California, San Francisco, discuss the barriers to implementing comprehensive primary care programs for frail elderly patients. "With increasing health care costs and an aging population, the United States needs to expedite the development and scaling up of cost-effective models of integrated care," the authors suggest. "Health care reform has given CMS [Centers for Medicare & Medicaid Services] new authority to promote the process."