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Editorial

An Imperative: Patient-Centered Care for Our Aging Population

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INTRODUCTION

The demographics of the aging United States population is rapidly changing; however, our healthcare system, designed in 1965 to care for the aging population, has not kept pace, nor is it at all aligned with today's—and tomorrow's—needs. In 1965, the average life expectancy was 70.2 years.[1] By 2020, the average life expectancy for Americans is predicted to be 80 years.[1] While the focus of the 1965 healthcare system was on managing acute illnesses, the healthcare system of the 21st century must prevent and manage chronic illnesses.

Chronic illnesses represent a major detriment to quality of life and create significant expenses for the Medicare program. This burden is primarily driven by hospital admissions and readmissions.[2] The current fee-for-service system, which pays providers for specific procedures and services rather than for the outcomes they achieve, reflects this outdated approach to care and is not sustainable.

This challenge presents an incredible opportunity for the healthcare community at large to adopt a new approach to healthcare delivery that consists of true patient-centered care coordination for the ever-growing population living with chronic conditions, from the first diagnosis of a chronic illness (which may require only nutrition and medication management) throughout the continuum of care (which may include an advanced illness with palliative care and hospice as options). This new approach would focus on care decisions made by the patient and family, and healthcare services would be provided where and when the patient prefers.

CHALLENGES OF PROVIDING PATIENT-CENTERED CARE COORDINATION

The Institute of Medicine has defined the characteristics of quality care as timely, safe, effective, efficient, equitable, and patient centered.[3] However, too often the care provided to Medicare patients for chronic illnesses is of uneven and poor quality.[4-6] Coordinating care for these patients is difficult for a multitude of reasons, the most important being (a) multiple healthcare settings involving multiple physicians and (b) a lack of patient understanding, education, or resources.

Chronically ill Medicare beneficiaries often see multiple physicians—all working within their own silo—with no one physician responsible for all care.[7] In our fractured delivery system, no one physician takes responsibility for guidelines-based care, and health information is most often not shared among these silos. The current system does not provide for a true care coordinator who ensures that the patient seamlessly transitions between care settings, nor is there an avenue for information to flow between the patient and all physicians involved in his or her care. In many instances, a patient is admitted to the hospital, but the primary care physician never knows about the event or any medication changes that resulted, thereby increasing the chances of a readmission. In fact, patients are at their most vulnerable after discharge. One in 5 Medicare patients ended up back in the hospital less than 30 days after discharge in 2003 and 2004 according to research from the *New England Journal of Medicine*.[8] Data from Healthcare Market Resources reveal that two of the most common reasons for hospital readmissions are medication errors and failure to see a physician—both of which can be reduced with effective at-home supervision of patients following hospital discharge.[9]

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Additionally, researchers have identified other factors that appear to contribute to the high rate of hospitalizations among chronically ill Medicare patients, including inadequate counseling on diet, medication, and self-care. The inability to follow the appropriate regimens leads to acute exacerbations of their chronic conditions, requiring hospital admissions and readmissions.[10-12] However, in many cases, physicians are unaware of patients' deficits in knowledge and skills. Some patients do not understand what a diagnosis means, the medication needed to manage the diagnosis, and the impact of diet on managing or exacerbating their chronic illness. Health literacy has been defined as the ability to understand and to act on health information.[13,14] In one investigation, fewer than half of the patients studied were able to list their diagnoses, the names of their medications, the purpose of those drugs, or the major side effects.[11]

Such a lack of awareness affects a patient's ability to comply fully with discharge treatment plans when leaving the hospital setting and with overall chronic illness management plans in the community. In addition to understanding the diagnosis and the associated medication or diet requirements, a patient must be able to access the resources needed to comply with the plan of care. Many chronically ill, fragile, and home-bound patients cannot obtain care because they lack access. A true care coordinator in a new healthcare delivery model would coordinate needed social resources, including transportation. Patient-centeredness means providing the needed care where and when the patient requires the care.

DEFINING HOW TO CARE FOR THE AGING POPULATION

Ed Wagner, MD, MPH, Director of the MacColl Center for Health Care Innovation, has said that the challenge is to organize the components of care into an integrated system of chronic illness care.[15] He proposed the Chronic Care Model as a primary care-based model. To provide this kind of quality care in a patient-centered world, the medical practice and hospital can no longer be considered the only venues of care. When any patient requires admission to a hospital for complications of chronic disease, that admission might be considered a failure of management. Today, whenever an elderly person is admitted to a hospital, he or she is simultaneously being discharged from the community. Providing care where the patient chooses to receive that care will define patient-centeredness: Healthcare in the home environment is more comfortable for patients, offers less risk of infection, saves healthcare dollars, and lends itself to the promotion of ongoing strategies to improve patients' quality of life. Experts estimate that home healthcare providers who care for the aging population are an increasingly essential segment of the healthcare system, especially in the United States.[16-18]

Patient-centeredness is a hallmark of quality care[3] and the focus of the medical home concept.[19] Until recently, focus has remained on the physician's practice being the "patient-centered medical home." The success of this patient-centered model will be more likely if primary care reforms are aligned with strategies that foster shared accountability among all providers for measurably and transparently improving the quality of care and reducing its cost.[20] Fisher has referred to this shared accountability as the "medical neighborhood."[21] For this strategy to work, all elements that support the patient's medical neighborhood must collaborate in coordinating care. Providing healthcare at home may be the most effective solution, and successful home healthcare can be one of the key elements of the medical neighborhood.

To be effective, the home health team must embrace new, chronic care–oriented concepts, processes, and technologies.[22] These home providers include nurses, nurse practitioners, and therapists skilled in chronic illness care, self-management support, and health coaching—all vital parts of the Wagnerian model. Centering vulnerable patients' primary healthcare in their homes may be one avenue for improving care and controlling costs.

COMPLETE CONTINUUM OF CARE

True patient-centered care coordination will require our healthcare system to approach palliative care and hospice as necessary components within the care continuum. We must leave behind grounded beliefs that care starts and stops at definitive points in time. For example, palliative care marks a practical and philosophical shift in how patients view their illnesses, from curing or overcoming disease to accepting and managing one's quality of life. Palliative care takes a holistic approach to relieving suffering in patients with advanced illnesses by tailoring treatment to people's values, caregiver needs, and home lives. By permitting the provision of comprehensive services earlier in the healthcare delivery process—empowering and educating the patient—the patient and family better understand the value in all treatment options, including palliative care and hospice.

Similarly, new service delivery and payment models must support these comprehensive services available at home and provide patients with a healthcare model that includes palliative care and hospice as care options earlier in the process—allowing individuals to live out their lives as they choose.

THE OPPORTUNITY IN HEALTHCARE AT HOME

To achieve this patient-centered system, the healthcare community must embrace new payment models. Some examples that have the potential to produce a true care continuum are (a) the Independence at Home pilots that create incentives for physician home visits to the highest risk population and (b) the Accountable Care Organization models that are crafted around aligned incentives for all providers based on improving outcomes and lowering costs. However, any new model must engage all providers and, most important, the patient, and must guarantee information sharing across the continuum.

Today, most patients—specifically those who are not part of an integrated system of care—must navigate a provider-centric solar system in which the orbit of one provider rarely intersects with those of any others. The inefficiencies of cost and time, along with the gaps in quality such a system has, have stranded many of the patients who most need quality, integrated care. The patient-centered medical home envisions a change in this disintegrated paradigm and presents a team-based care system that uses a panoply of healthcare providers—physicians, nurses, nurse practitioners and physicians' assistants, social workers, dietitians, and other professionals—to provide coordinated services for each patient.

Patient-centered care across a medical neighborhood must weave together physicians and their care teams, acute care hospitals, and postacute providers in a seamless tapestry that continually touches each patient. If we can develop such a model to coordinate effective management of chronic conditions within the aging population, we will have achieved the goal of high-quality, cost-effective, accessible care.

CONCLUSION

The healthcare reforms envisioned by the Affordable Care Act depend on the health systems of the future adapting to the needs of the current population with chronic illnesses that will require truly patient-centered care coordination. This new approach to healthcare delivery permits the provision of comprehensive services earlier in the healthcare delivery process and continues throughout the entire continuum of care while empowering and educating the patient. This system allows the patient and family to better understand the value in all treatment options, including palliative care and hospice options, when they reach that part of the continuum.

To paraphrase the Institute of Medicine,[3] quality healthcare is the right care, but only the right care delivered at the right time for every patient. Only when all healthcare providers recognize the value that each part of the team—both acute care and postacute care providers—can bring to the patient's medical home will that vision of quality be attained. Healthcare delivery with a payment system that allows for the provision of services based on the patient's needs much earlier in the diagnosis has the ability to truly be a patient-centered medical home.

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