Ivinson Medical Group

Laramie, Wyoming

THE JOHN A. HARTFORD FOUNDATION
GWEP·CC
Geriatrics Workforce Enhancement Program Coordinating Center
MANAGED BY THE AMERICAN GERIATRICS SOCIETY

GWEP-CC CASE STUDY: THE JOURNEY TO AGE-FRIENDLY PRIMARY CARE

About Us

The Geriatrics Workforce Enhancement Program Coordinating Center (GWEP-CC) Case Studies present a broad range of cases drawn by Geriatric Workforce Enhancement Programs (GWEPs) and their primary care partners to take learners through their experiences implementing the 4Ms. Case study authors participated in the 2020 GWEP-CC Age-Friendly Health Systems Action Community and are recognized by the Institute for Healthcare Improvement (IHI) as either an Age-Friendly Health System Participant (Level-1) or Age-Friendly Health System – Committed to Care Excellence (Level-2).

The GWEP-CC, led by the American Geriatrics Society, is supported by The John A. Hartford Foundation, and serves as a strategic resource for the Health Resources and Services Administration (HRSA)'s GWEP programs.

For more information, please contact the GWEP-CC at GWEPCC@americangeriatrics.org.

Ivinson Medical Group (IMG) adjoins Ivinson Memorial Hospital in a medical office building and offers outpatient primary and specialized care in the rural environment of Laramie, Wyoming. Specialty care includes geriatrics, internal medicine, family medicine, general surgery, orthopedics, pediatrics, obstetrics and gynecology, and ear, nose and throat.

Becoming an Age-Friendly Health System originated through discussions with our geriatrician (Dr. Emma Bjore) and our clinical pharmacist (Dr. Tonja Woods). Having a geriatric team at IMG allows for more targeted initiatives, many focusing on achieving age-friendly goals. We wanted to become an Age-Friendly Health System to ensure we better documented important focal points of care (eg, "what matters") and filled identified gaps in the health system (eg, advance care planning). Creating a more formal workflow to include the **4Ms** supports patients in achieving their health goals as they age. Integrating patients, caregivers, and families is critical to the process of achieving personal health goals, and the **4Ms** provide an excellent framework for us as a healthcare team to facilitate reaching goals.

We began our age-friendly journey in early 2020 by working toward Level 1 recognition. Through team meetings and focused planning sessions, we developed our plan and description to implement the **4Ms** into our daily care. We received Level 1 recognition in July 2020 and are working toward Level 2, the top designation awarded by the Institute for Health Improvement (IHI). Our AIM statement is as follows: *By December 2021, Ivinson Medical Group (geriatric team-focus) will articulate how it operationalizes 4Ms care and will have provided that 4Ms care in 20% of encounters with patients 65+ years old.*

Age-Friendly Health Systems
An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

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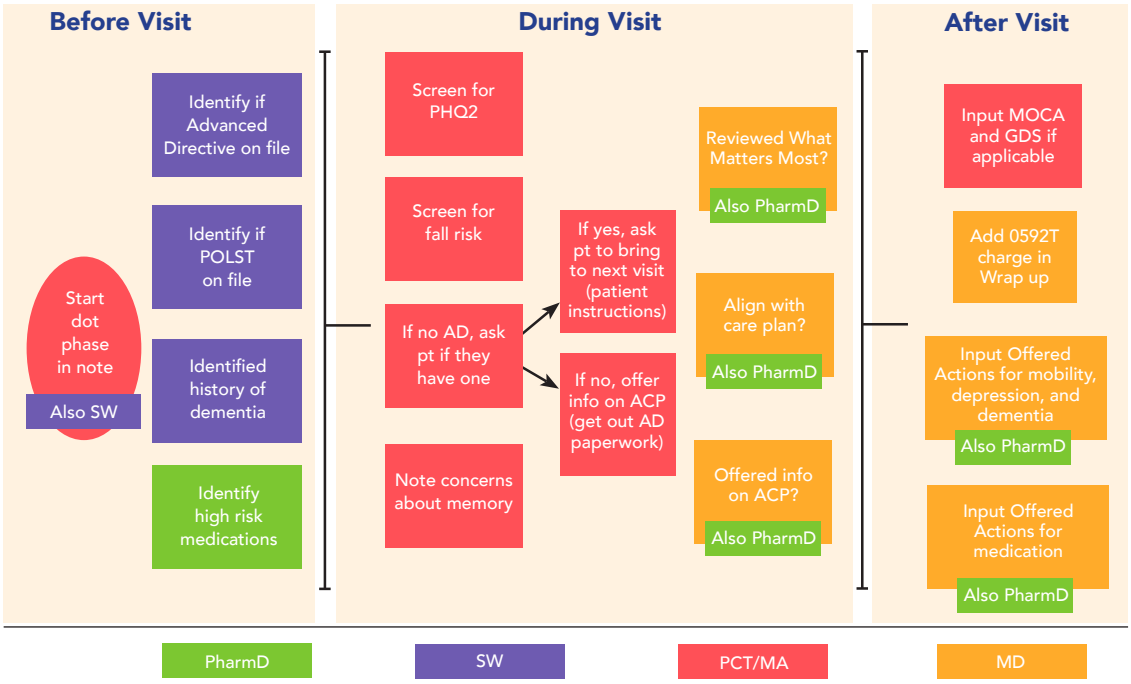
What We Are Doing

The **4Ms** have been integrated into our clinical practice through a great deal of work by our geriatrician, pharmacist, and patient care technician, who dedicated a large portion of her first several months with the geriatric team to create a system of documentation within the electronic health record that encompasses the **4Ms**. This documentation is amendable by all team members to allow for a wide variety of engagement with patients.

Adapting to the **4Ms** took time, but we were able to create and implement a workflow (Figure 1) that involved and engaged all team members. Our geriatrician and/or pharmacist were able to capture the **4Ms** during both annual wellness visits and scheduled follow-up appointments. Our patient care technician and social worker identified patients who would benefit from age-friendly care during their appointments. Our social worker also reviewed patient charts to determine if there was a history of dementia and appropriate documentation surrounding "what matters" to the patient. This documentation consisted of patients' advance directives and Physician Orders for Life-Sustaining Treatment (POLST). The role of the patient care technician includes screening patients for depression, dementia, and fall risk, and introducing the concept of age-friendly care. The role of the physician, clinical pharmacist, and registered nurse is to conduct "what matters" conversations, review results from screenings and offer necessary actions, and align the patient's care plan with "what matters" to achieve desired health goal outcomes.

Figure 1. IMG 4Ms Workflow



What We Found

Our current efforts toward achieving Level 2 designation are truly gratifying. Integrating this framework into patient care is affirming and inspiring for every member of our team. Because of this focus, our team members are now doing more meaningful chart reviews, building stronger relationships with our patients, and providing better patient-centered care. Patients have been responding positively to the conversations fostered by the program, enjoy discussing their priorities and health goals, and are participating with more input into their care plans.

We have found many benefits from having "what matters" conversations. Since implementing this framework in June, we have successfully completed 35 POLSTs and advance directives, providing a foundation for patients and providers to mutually understand the patients' health goals. The conversation around advance care planning is continual and evolving and does not end with the completion of these documents.

Case Study

A 73-year-old woman expressed her thanks and gratitude for time spent discussing the **4Ms**. Her medical history included hypertension, cardiomyopathy, heart failure, atrial fibrillation, transient ischemic attacks, a mechanical heart valve, a pacemaker, osteoporosis, and seizure disorder. She is currently raising her 9-year-old grandson by herself on a fixed income.

During the **4Ms** discussion, she became emotional and described that her grandson is what matters to her because he is "all she has." She shared that his parents are both incarcerated, and she is worried that if her health takes a turn, no one would be there for her grandson. She did not have an advance directive prepared or POLST filled out, and she did not want her grandson to "have to deal with that on top of everything else." But she was also too overwhelmed to make an appointment with an attorney to address these matters.

Our pharmacist worked through the **4Ms** with the patient and had a comprehensive discussion on advance care planning. The patient was also scheduled for follow-up with cardiology as needed. She was grateful to have a resource to help her develop an advance care plan and complete her POLST without incurring legal fees. In addition, she was able to have her follow-up cardiac care scheduled during her primary care visit. Incorporating the **4Ms** workflow into the patient visit allowed her to meet her goals.

Maintaining the 4Ms

IMG began implementing the **4Ms** with two providers (our geriatrician and pharmacist), which allowed the **4Ms** to be followed closely and reduced potential for error. Having our pharmacist work with patients was very beneficial because she sees patients of a number of primary care providers within the clinic. The geriatric team hopes to engage other providers as the process becomes more seamless.

Patients are referred to community-based organizations when needs for these services are identified such as mental health, caregiver support and education as well as home health needs. The community-based organizations that the geriatric team most commonly utilizes are LIV Health, Encompass Home Health, Home Instead and the Dementia Support Center. Each of these agencies provide patients with care in many areas. LIV Health offers in-home therapy and case management, which is essential for many geriatric patients that are homebound. Encompass Home Health is a critical agency, offering home health services that include physical, occupational and speech therapy. Encompass also provides support with in-home nursing care. Home Instead is an agency that provides caregivers to visit with patients in their home and provide non-medical care. Their services include housekeeping, cooking, transportation and social interaction. The last care agency most frequently utilized is the Dementia Support Center, at the University of Wyoming Center on Aging, funded by the Wyoming Geriatric Workforce Enhancement Program (GWEP). The support center offers continued education for patients and loved ones with dementia as well as a variety of other resources, activities and training events.

Lessons Learned

Becoming an Age-Friendly Health System was no easy task, but the benefits gained from implementing the **4Ms** have far outweighed the growing pains. Working toward our Level 2 recognition has been quite rewarding as we learned more about our patients and connected on a new level. With all new initiatives and workflows, there are sure to be challenges. Discovering ways to implement the **4Ms** into the practice proved to be an unforeseen challenge, because it did not appear that ample information was shared through IHI. Understanding how to document appropriately and how to best collect data was left to our patient care technician, who found that resources on these processes and procedures were lacking. Although the IHI website has many testimonies from health systems that have reached Level 2 recognition, specifics on how the Level 2 designation was achieved were not present. Our team was best served when we found an additional helper to focus primarily on the Level 2 process.

We also struggled with how to best document this information in the electronic health record in a meaningful way. We wanted the information to be uniform and minable for future use. We developed a "dot phrase" to gather data in our note templates and then used a "dummy code" in Epic (software) to extract how many patients we were able to reach. This process took a great deal of time because it required meeting with multiple teams in our health system, including quality improvement, compliance, software support, and information technology. In addition, we recognized that the amount of time needed to adequately work through the **4Ms** during a patient visit is easily underestimated. We needed to continue to modify workflows to accommodate patient needs. These very important conversations cannot be rushed and sometimes must be carried over into another visit to make sure we remain focused on patients' health goals.

Our advice to others who are considering implementing the **4Ms** and age-friendly health care is to jump in and get started. Trial and error may be needed to see what works best for your team and your patients. Mistakes will likely happen, but they are an opportunity to learn and make adjustments for improvement. Beginning the process may appear daunting but seeing the positive impact that occurs is wonderful. Opening up communication and having these important discussions with patients builds better relationships and improves the ability to achieve patients' health goals.

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