

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.

UNC Geriatrics Clinic is a primary care practice located at 100 Eastowne Drive, in Chapel Hill, North Carolina.

We serve the state, and most of the patients come from the greater Triangle area. Our clinic primarily serves older adults, 65 and older, with a patient-centered approach to care. However, we also see some patients younger than 65 who are experiencing chronic conditions commonly experienced by a geriatric population such as falls, dementia, and incontinence. Our mission is to help patients meet their personal health goals and walk with them through all stages of later life.

Based on data from September 7, 2021, we see a total of 3,217 patients, 94% of whom are older than 65. Of these patients, 65% are female and 35%

are male; 38 patients do not have gender information in our system, which accounts for discrepancies between the total number of patients and the sum of our female and male patients (Figure 1).

Physicians at our clinic are certified in both internal or family medicine and geriatrics, meaning that we can meet both patients' primary care and aging-related needs. In addition, our team includes two geriatrics nurse practitioners, a neurologist, a geriatrics psychiatrist, and a geriatrics pharmacist. On the population health side, we have a geriatrics social worker and a population health specialist who assist patients with care management and resource coordination.

We are a teaching clinic and train three or four new geriatrics medicine fellows a year in

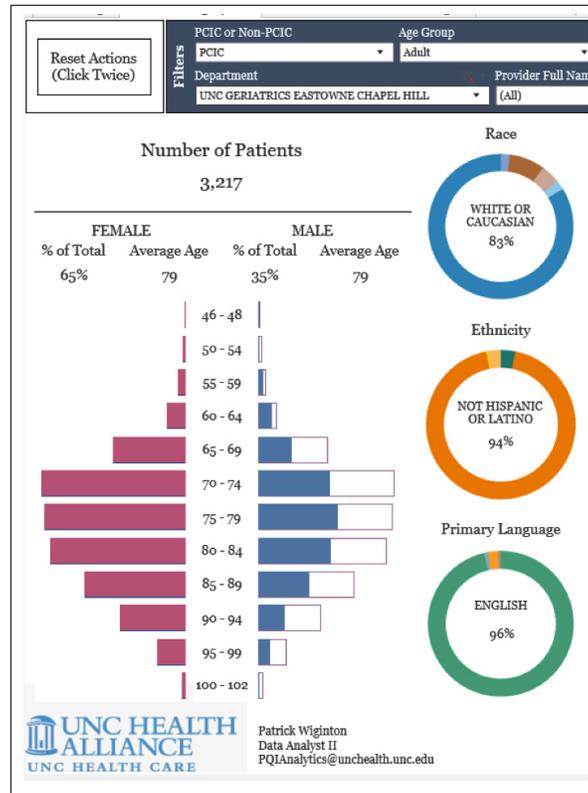


Figure 1. Patient demographics for UNC Geriatrics Clinic at Eastowne

dementia care, advance care planning, gait assessment, and polypharmacy. These fellows work closely with our attending physicians and the geriatrics pharmacist while managing their own patient panel.

Prior to the COVID-19 pandemic, the UNC Geriatrics Clinic became certified as a Level 1 Age-Friendly Health System (AFHS) in March 2020. We became an

AFHS because of the importance of the 4Ms as part of evidence-based care for older adults and to represent the clinic's commitment to quality care. We are currently working toward Level 2 AFHS certification, which includes conducting patient observation and chart review to audit our clinic's practice of the 4Ms.

Our Approach

An AmeriCorps MedServe fellow observes and records the 4Ms in action during patient visits. MedServe fellows are recent college graduates who have completed a pre-medical curriculum and are taking time off before applying to medical school. MedServe fellows are bright, service-minded, and eager to learn. They undergo a rigorous two weeks at the AmeriCorps Training Institute to prepare for their roles. In addition, AmeriCorps hosts quarterly skill summits across the state to expose students to key medical concepts and help them prepare for the next stage of their medical education.

As a geriatrics clinic, we currently practice many components of the 4Ms. We have outlined how each of the 4Ms are addressed during a clinical visit in the following sections.

The 4Ms

What Matters: Historically, discussions of what matters have been provider-driven, but they are discussions about the patient's priorities and their future direction of care. The provider-driven conversations often focus on assigning a health care power of attorney, completing a living will, medical orders for scope of treatment, and do-not-resuscitate forms.

Medication: Medication reconciliation is typically conducted at the beginning of every visit during the triage process. Our care partners review the patient's medication list in our EMR with the patient and/or their caregiver and adjust the chart to reflect any changes in medication use. Our geriatrics pharmacist also conducts more detailed medication reconciliations for complex cases, when needed. In addition to regular medication reconciliations, our clinic has an overarching focus on deprescribing medications that are in-

consistent with mobility and mentation goals for older adults, such as benzodiazepines and anticholinergic medications.

Mentation: Our care partners (CMAs, LPNs, RNs) conduct annual depression screenings (PHQ-2 and/or PHQ-9) during their triage process. Once the screening has been completed, a provider (physician, nurse practitioner, or physician assistant) must approve the addition of the results in the electronic medical record (EMR). In situations when patients have greater mental health needs, their provider may refer them to our geriatrics psychiatrist.

Dementia is addressed in clinic by the provider and can include assessments such as the Mini-Mental State Examination (MMSE), the Saint Louis University Mental Status (SLUMS) examination, and the Montreal Cognitive Assessment (MoCA). Similar to the situation with mental health needs, if providers identify a greater need for support with dementia patients, they may send a referral to our neurologist and/or to our geriatrics psychiatrist.

Mobility: Mobility is primarily addressed through assessments of gait and falls. Falls are assessed annually with a two-part questionnaire by the care partner during triage. Providers conduct a diagnostic gait evaluation when medically indicated. These evaluations are used to determine if patients are exhibiting common patterns of gait abnormalities, such as those associated with peripheral neuropathy or Parkinson disease. If mobility needs are identified, providers may refer patients to physical therapy or request durable medical equipment to help patients meet their ambulatory goals. These referrals are typically facilitated by our social worker and population health specialist.

What We Found: Outcomes

Table 1 summarizes the results of 10 real-time patient observations conducted by the MedServe fellow; the 4Ms were conducted 88% of the time at our clinic. Patients were observed for the entirety of their visit, beginning with triage and ending with the check-out process. Notes were collected during the visit, specifically focusing the on 4Ms. Chart review was also used to supplement the patient observations. For example, if an MMSE, SLUMS, or MoCA was not conducted during the visit, but a provider at our clinic had previously documented such an assessment in the EMR, it was counted as fulfilling the Dementia category of the 4Ms. In addition, for What Matters, conversations that centered around what patients hoped to gain from their care and their priorities were counted in addition to more formal conversations about advance care planning.

Table 1. Audit of the 4Ms (observed throughout patient visits).

Patient	Mentation	Mobility	Medications	What Matters
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	✓
4	✓		✓	
5	✓	✓		✓
6	✓	✓	✓	✓
7	✓		✓	✓
8	✓	✓	✓	✓
9	✓		✓	✓
10		✓	✓	✓

How We Spread the 4Ms and Became an Age-Friendly Health System Practice

UNC Geriatrics Clinic has engaged with the community in a variety of ways, including collaborating with caregiver support programs and organizations that provide home-based services for geriatric patients. Our social worker often refers patients to the Duke Dementia Family Support Program and the Dementia Alliance when patients and caregivers are struggling with mentation-related issues. In addition, UNC Geriatrics Clinic has partnered with Premier Home Health Care Services and Elderfit In-Home Rehab.

Both organizations provide home-based care, allowing our patients to stay in their homes for as long as safely possible. For many of our patients, being able to stay at home is one of their main priorities and having home care or in-home physical therapy services can help them with these goals.

Lessons Learned

Having a MedServ fellow championing the 4Ms and using observation has embedded AFHS care in our culture and daily workflow. One of the primary challenges we have encountered in attaining Level 2 AFHS certification has been the COVID-19 pandemic. In 2020, we had to suspend our efforts to reach Level 2 certification as our clinic shifted to providing services primarily via telehealth. Adjusting to new modes of communication posed some challenges in the initial transition to telehealth. In addition, teaching our patients and their caregivers how to use new technology was difficult, especially given our geriatric patient population. We have recently reinitiated our efforts to attain Level 2 AFHS certification.

Given that we are a geriatrics clinic, we have a unique perspective on the journey toward AFHS certification. Many of the 4Ms were already being addressed by our providers long before the AFHS certification. However, the model has provided us with new opportunities to reassess our workflow and identify areas for improvement and refinement. We hope that the AFHS model can make its way into many other clinics and increase awareness and focus on the specific needs of geriatric patients.

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