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Integrating Geriatrics in Primary Care: Progress and Prospects

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Excellence in Primary Integrated Care-Geriatric Patients

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Case Study

Integrating Geriatrics in Primary Care: Progress and Prospects

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Educational Objectives

1. Demonstrate the need for primary care redesign to better meet the needs of older patients.
2. Identify prospective redesign solutions.
3. Appreciate educational implications that redesign engenders.

Introduction

As readers of *Age in Action* are well-aware, the “Silver Tsunami” is upon us. Nowhere is this realization more acute than in primary care, wherein the vast majority of older adults receive medical services. Unfortunately, there is often a mismatch between the structure of primary care and the needs of older patients. We first identify characteristics of primary care that lead to this mismatch, and then describe

our experiences with an ongoing redesign intervention. We conclude with a brief consideration of the educational implications of this effort.

Background: The Challenges of Primary Care “As Usual”

Primary care of robust older adults can occur with our current system, which relies on short visits of 15-20 minutes and the knowledge the participants gain through on-going follow-up over time. This is not sufficient, however, for vulnerable elders, those afflicted with geriatric syndromes such as falls and dementia, as well as poorly regulated multimorbid chronic illnesses.

Proper care of these complicated issues is extremely challenging in brief encounters wherein the clinician is expected single-handedly to identify and manage multiple, often acute, concerns as well as chronic illnesses. There usually is little time for systematic assessment, education, coordination of care, and attention to psychosocial needs. In other words, primary care as it currently exists is prey to “tyranny of the urgent,” the need to respond to

presenting and often acute concerns, while underlying determinants of these issues go unaddressed (Moore, 2006).

Primary care is also “silo-ized” to a considerable extent. There is often a disconnect between various sites and providers of care, making transitions hazardous. There is no system for communication between primary care and other disciplines with important roles in geriatric care, such as nursing, social work, and pharmacy. Moreover, a divide exists between primary care and the system of community-based services and supports. This divide is especially noteworthy as social and behavioral determinants of health account for about two-thirds of the variance in adverse health outcomes, such as hospitalizations and preventable deaths (Alley et al., 2016).

To understand the difficulties of “primary care as usual” for complex older adults, let’s meet Mr. A.

Case Study 1

Mr. A, 79 years old, is discharged following a hospitalization for heart

Inside This Issue:

VCoA Editorial, 7
DARS Editorial, 9
VGEN Faculty Development, 11
ARDRAF Recipients, 12

The Paradox of Aging, 15
Age Wave Re-Cap, 16
VCU Assisted Living Program, 17

Shepherd’s Center, 17
Calendar of Events, 18
Walks to Remember, 20

failure. Mr. A does keep his one week follow-up appointment. His clinician updates the medication list, orders some laboratories, reviews the need to follow-up with his cardiologist, and asks him to return in a month. However, Mr. A no-shows for this appointment and is brought by ambulance to the emergency room a few days later with decompensated heart failure, requiring readmission. Mr. A is also delirious, has fallen, and is dehydrated. He is stabilized, but is too deconditioned to return home and is transferred to a skilled nursing facility. He is eventually discharged to live with his daughter, who has had to quit her job to be his caregiver. He is no longer able to live independently.

What went wrong for Mr. A? There is no simple answer. However, several possibilities come to mind: Did Mr. A understand the instructions given him at discharge? Were there sensory impairments that got in the way? Did he have pre-existing cognitive impairment? Could he afford his medications? Did he know the warning signs that his condition was worsening? Did he lack transport to doctors' appointments? Was his home environment safe? Was he drinking? What was the involvement of his caregiver?

Ideally, Mr. A's doctor would have assessed the above questions, realized that he was at high risk and put together a more proactive, targeted plan to avert the readmission and loss of independence. The fact that this did not occur is not an indictment of the individual physician's knowledge and judgement but is instead a system issue. Mr. A's plight vividly underscores the need

for a different primary care approach in which challenges such as those listed above can more readily be identified and addressed.

A Redesign Initiative: Progress to Date

In order to foster redesign, the federal Health Resources and Services Administration (HRSA) initiated Geriatrics Workforce Enhancement Program (GWEP) grants in 2015. The GWEP program represented a major shift from prior HRSA funding in that GWEPs must include clinical patient care activities, such as practice redesign initiatives that integrate geriatrics in primary care and build interprofessional education around this framework.

The Virginia Geriatric Education Center, a consortium of Virginia Commonwealth University (VCU), Eastern Virginia Medical School (EVMS), and the University of Virginia (UVA), led by the Virginia Center on Aging (VCoA) at VCU and partnering with several other organizations, was one of 44 GWEP awardees nationwide. EVMS's Department of Family & Community Medicine addresses required integration of geriatrics in primary care practice and training with a program entitled Excellence in Primary Integrated Care-Geriatric Patients (EPIC-GP).

The workings of EPIC-GP is illustrated by the story of Ms. B.

Case Study 2

Ms. B is also 79 and is seen one week following discharge from a heart failure hospitalization. Her doctor develops a plan like that

devised for Mr. A but suggests Ms. B get a Medicare Wellness Visit (MWV) as her next appointment. The physician introduces Linda, one of the department's RN care managers, to describe the wellness visit and get Ms. B scheduled. Linda finds at the MWV that Ms. B has had several falls and is unsteady getting up. She also notes that Ms. B has limited understanding of how to care for her heart and has questions about the future if her heart failure should worsen. Linda makes sure Ms. B keeps her follow-up with her doctor. In addition, Linda refers Ms. B to fall prevention and chronic illness self-management classes offered at the regional area agency on aging. When seen three months later, Ms. B feels well, has increased confidence in her ability to avoid falls and manage her heart failure, and is actively discussing advance care wishes with her family.

What went right for Ms. B? Several things. First, the MWV identified important unmet needs that were not evident on the first office visit: she was falling, had limited health literacy, and was interested in advance care planning but did not know how to go about it. Second, Linda leveraged her relationship with Ms. B to ensure that she did get needed medical follow-up. Third, Linda referred Ms. B to community-based services to address her issues of falls and limited health literacy. Fourth, Linda facilitated the process of advance care planning by providing information and helping her schedule a visit dedicated to this issue with her primary care clinician.

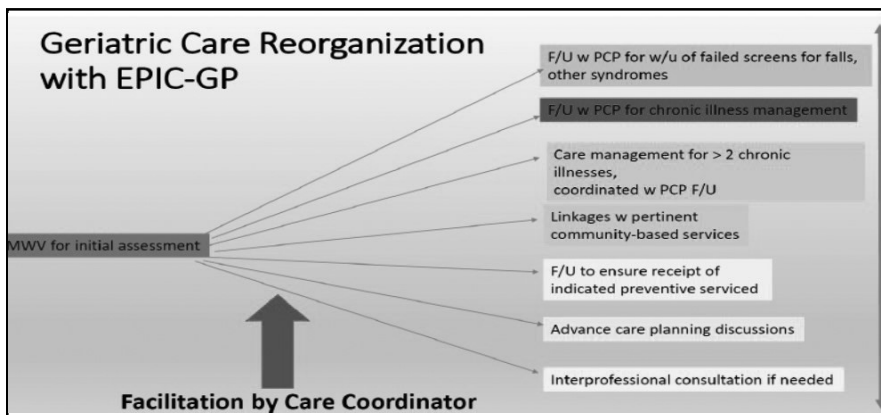
More generally, Ms. B benefitted

from systemic assessment, active care coordination and management, and resource linkage. These principles are the crux of EPIC-GP, which overcomes “tyranny of the urgent” by using the Medicare Wellness Visit (MWV) for assessment, combined with active coordination of follow-up for identified needs and care management for high-risk patients. The approach is summarized in Figure 1.

needs (e.g., failed screens for geriatric syndromes; inadequately treated chronic illness) with subsequent care. A care manager facilitates scheduled follow-up with continuity clinicians, entry into non-face-to-face case management for high risk patients, linkages with pertinent community resources, appointments dedicated to discussion of advance care preferences, follow-up on preventive care, and interprofessional geriatric consultation if

MWV and the fact that it is a fully covered benefit with no additional co-pays (although there may be co-pays for other services like immunizations, lab draws, or evaluation and management of other clinical issues during the wellness visit), the MWV benefit is surprisingly underutilized nationally and at our EVMS practices. In 2015, only 153 of some 4,000 EVMS Medicare patients ages 65 and above completed a MWV.

Figure 1: Structure of EPIC-GP



The MWV, an annual benefit for Medicare enrollees, is an hour-long visit to review and update medical histories, the status of chronic conditions, medication reconciliation, attention to preventive service needs, screening for geriatric syndromes, and discussion of advanced directives. In addition, the MWV also includes a health risk assessment to help clinicians identify and address adverse health behaviors. In other words, the MWV is a geriatric assessment geared to primary care.

It is widely recognized that geriatric assessment must be linked to subsequent management to be effective. Accordingly, there is actively guided follow-up of MWV-identified

needed. Care management in EPIC-GP goes beyond coordination and includes functions of monitoring, self-management support, caregiver care, resource linkages, and care plan development (Aliotta, et al., 2008).

The sections to follow detail our progress to date in implementing this clinical model, as well as prospects and future directions. Similarly, we discuss current status and future plans for educational programs based on this clinical framework.

Progress to Date: An Exercise in “PDSA”

Despite the face validity of the

Thus, low MWV recruitment was a “rate-limiting” barrier that would have to be addressed if EPIC-GP was to get off the ground. We responded to this challenge using a PDSA approach. PDSA stands for Plan, Do, Study, Act, a model for testing quality improvement ideas quickly and easily (Leis & Shojaania, 2016). In contrast to research, PDSA methods do not require formal design, sample size calculations, or statistical methods.

Results are pragmatic and measures are simple. The goal is programmatic improvement rather than new or generalizable knowledge. PDSA methods are prominently featured in GWEP projects to foster rapid development and refinement.

The “P” in PDSA stands for Planning. As we had little idea why MWVs were so under-used, we needed planning information and so began with a survey based on scant extant literature and some guesses based on experience. Our aim was to understand barriers. We first surveyed patients (those who had [N=29] and had not [N=70] had a MWV) at our two clinics during January and February of 2016.

Patients were 50.4% female, 33.4%

African-American, 53.2% white, and 13.4% percent “other”. Mean age was 74.2 years. Demographic findings did not vary by practice site and hence are pooled. Demographics did not vary between MWV recipients and non-recipients. Response rates for survey items were between 85% and 100%. Results are summarized in Table 1.

wanted to get scheduled for one. Several noted that being asked to fill out the survey by a staff member who clearly believed in the value of the MWV had encouraged them.

We also surveyed our providers and received responses from 38 of 64 (59%). Most thought the MWV was valuable, but were deterred by

recruitment from approximately 10 per month to 30. Based on this initial success, we expanded the approach by engaging other nursing staff as recruiters (the “S” [Study] and “A” [Act] of PDSA).

At present, we are a year into our implementation. We have completed 489 MWVs from April 1, 2016 through March 31, 2017, a 320% increase over the 153 completed in 2015. Details of our intervention (Bluestein, et al., 2017) and an accompanying editorial (Adler, 2017) have just appeared in *Family Practice Management*, a refereed journal sponsored by the American Academy of Family Physicians that is widely read by practicing primary care clinicians.

Table 1: Perceptions of the MWV by Recipients and Non-Recipients

	<i>Had MWV (N = 29)</i>	<i>Did not have MWV (N = 70)</i>
*Heard of MWV	N/A	37%
*Heard negative things about MWV	N/A	13%
*Concern for unexpected costs	3.4%	15%
*MWV suggested by your doctor?	89.7%	18.6%
**Importance of history & medication review	96.6%	95.7%
**Importance of preventive care	96.6%	92.9%
**Importance of screening for community-based service needs	96.6%	84.3%
**Importance of screening for geriatric syndromes	89.7%	87.1%
**Importance of advance care planning	96.6%	82.9%

* Yes ** Important or very important

Challenges and Future Directions

Getting patients to undergo MWVs is necessary, but not sufficient. This is underscored by our quality metrics, comparing patients who had MWVs to those who had not. We did relatively well with preventive care. MWV recipients were about 6% more likely to have gotten a colonoscopy and 12% more likely to have gotten a mammogram. MWV recipients were more than twice as likely to have completed an advance directive and other advance care planning documents (11.5% vs. 5.3%), though overall numbers are still low.

These findings indicated little to support “bad press,” concern about hidden costs, or unmet needs as reasons for underusing the MWV. Most respondents felt that various items in the MWV were important or very important. Most who had an MWV did so at the recommendation of their physician. Most who had not had an MWV had not heard of it, and, unexpectedly,

its complexity and time demands.

Together, these findings suggested our “D” (Do) in PDSA, an intervention leveraging the weight of the physician’s recommendation, combined with enthusiastic recruitment by an RN care manager who would conduct the visit, thereby unburdening the physician. A one-month observation period increased MWV

Some of these positive differences may have been due to counselling received during the wellness visit. However, it is also possible that persons who got MWVs had a more positive orientation to health to begin with, motivating both greater use of preventive care and advance

care planning, as well as obtaining the wellness visit.

It is also noteworthy that chronic illness metrics do not vary by group. Approximately 39% of hypertensive patients are not at goal and about 16% have poorly controlled diabetes, regardless of MWV status. This lack of difference suggests that, even though the majority of our MWVs were conducted by experienced RN care managers, we are not leveraging their expertise to improve quality metrics through education, self-management support, and coordination.

An important process metric in regard to chronic illness outcomes is improving “health confidence.” Health confidence is a proxy for patient self-efficacy, self-care, and self-management, all of which pertain to patient engagement, which in turn is highly correlated with better health behaviors and health outcomes (Wasson & Coleman, 2017). Health confidence is assessed as a single question: “How confident are you that you can control and manage most of your health problems?” Responses are on a scale from 1 (totally unconfident) to 10 (absolutely certain). Responses in the range of 4-7 indicate patients are preparing to take action and perhaps most likely to benefit from information and support. Ratings over 7 imply successful enactment of behavioral change.

What is the health confidence of our patients? An audit of 50 charts indicated mean confidence levels of 8, mostly around healthy eating and exercise. A subsequent review, however, showed no evidence of

behavioral change. These unrealistically high levels have several potential explanations: a) Social desirability bias, a desire to please an important “other,” in this case the care manager; b) Not knowing what you don’t know about barriers; c) Simple fatigue and lack of attention, as Health Confidence is assessed in an action plan at the end of an hour-plus visit.

The results of this audit are the “P” in our second PDSA cycle; we know we have a problem. As this is written, we are engaged in “Ds” (Dos) to test various alternatives, such as use of visual scales, different wording of the health confidence question, and differences in when the question is asked.

Getting a better gauge on health confidence brings to mind the aphorism from the movie “Field of Dreams”: “If you build it, they will come.” In other words, identifying a larger number of patients needing help with behavioral change implies a need for resources to accomplish this. Our care managers can help with this, to be sure. However, the increased volume will necessitate additional resources to support behavioral change that ultimately affects quality metrics. This can most likely occur through outreach and partnerships, with an area of future endeavor being to seek “win-win” relationships with our area agencies on aging and other community-service organizations that offer support services and disease self-management programs. This approach also has the benefit of working to address social determinants of health, an approach that is not widely possible in “primary care as usual.”

Educational Implications

EPIC-GP is first and foremost a clinical innovation. However, GWEP programs have important educational mandates and any innovation is bound to “wither on the vine” unless it is understood and valued by upcoming generations of learners in health care professions. Accordingly, EPIC-GP incorporates three educational initiatives: training in clinical geriatrics, the social model of care, and advance care planning in the non-acute, ambulatory setting. To date, we have addressed these through lecture format and creation of resources (clinical templates). A 2016 “visiting professorship” showcased the import of social services and the social model of care through a two-day visit by Dr. Dick Lindsay, a retired geriatrician from UVA, and Adrienne Johnson, CEO of Virginia Navigator. They spoke to multiple audiences through grand rounds presentations and informal discussions. We have also used a series of didactic (lecture) sessions to foster learning about basic topics in advance care planning.

While we have expended considerable effort in providing various presentations at EVMS, especially on topics that lie outside “medicine” such as understanding/leveraging community-based services and supports, and advance care planning, these interventions have not led to practice change. This is not surprising, however, given the complexity of the topics and the limits of traditional classroom/lecture activities.

On the other hand, the success of academic detailing has been a very

positive surprise. This is a recent undertaking wherein patients who have failed geriatric screens, such as the Mini-Cog or the Up & Go test for falls, are being scheduled for follow-up evaluations by their primary care clinicians, most often resident physicians. These appointments are actively tracked, enabling Dr. Blustein and other EPIC-GP team members to touch base beforehand, review evaluation approaches, provide resources, and be available to answer further questions. As most clinicians learn and internalize information in the context of patient care experiences, the success of this individualized approach was to be hoped for. We were not prepared, however, for the extent of the enthusiasm academic detailing has generated, suggesting that this approach be expanded to address not just core clinical topics but also use of social services and advance care planning.

Conclusion

EPIC-GP has achieved notable initial successes, leveraging PDSA methods to understand obstacles and test successful interventions. Challenges remain, most notably using care management to improve quality metrics and developing creative approaches to increase health profession learners' self-confidence in translating what they learn to practice change in working with the human services system and advance care planning. PDSA methods will be vital to moving these initiatives forward.

These approaches will be important to primary care practice in the new world of value based reimbursement under the new CMS programs

“MACRA” and “MIPS,” the Medicare Access and CHIP Reauthorization Act and the Merit-based Incentive Payment System, respectively (Mullens, 2016). Going forward, Medicare Part B payments will be adjusted based on scores from performance categories which include quality, practice improvement activities, 30-day readmissions, and eventually lower costs. Higher performance will result in bonuses, below average performance with penalties. MWV completion, follow-up of positive MWV findings, and application of PDSA methods can all contribute to higher scores in these parameters.

Despite the “face validity” of linking MWV assessment with subsequent care management, it is imperative to document that this model improves outcomes. Showing the value of these services will allow their continuance, to the benefit of patients, families, and new cohorts of learners.

Study Questions

1. What are common barriers to primary care of older adults?
2. How can the Medicare Wellness Visit be used to improve the primary care of older adults?
3. Why is teaching geriatrics in primary care best done by supporting learners at the point of care?

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