The Management of the Development of a Geriatric-Friendly Practice Toolkit for Use in the Primary Care Setting: a Multi-Tiered Intervention to Improve the Health of Older Adults

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Abstract

The geriatric population of the United States is growing in size at a rate faster than any other segment of the populace. Providing effective, high quality care for this aging cohort is a critical issue facing our health system. The number of geriatricians – the specialized physicians who are trained to care for this aging population – has not kept pace with the growth of the geriatric population. Geriatricians are helpful in working with the geriatric patient to provide patient-centered care, specifically working to maintain and improve the quality of life as compared to working with significantly younger populations where physicians focus more intensively on the quantity of life.

This paper examines the growth of the geriatric population, discusses the problem of the lack of geriatricians in the United States, analyzes best practices with respect to the care of the geriatric patient, and details the creation of a geriatric Toolkit by the Jewish Healthcare Foundation for use in Primary Care Practices. The goal of the Toolkit is to help the primary care practices focus on the patient's quality, not just quantity, of life.

The public health significance of this work is that providing the best care for the geriatric patient improves not just the patient, but society as a whole. By formulating a user-friendly tool, the evidence for how to effectively care for geriatric patients can be presented to practice managers and healthcare providers in an efficient way to assist them in improving the health outcomes of geriatric patients.

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Preface

This essay is dedicated to my four beautiful children, my eternally optimistic husband and all my extended family. Without them, none of this would have been possible.

1.0 Introduction

The following essay describes the development of a Geriatric-Friendly Practice Toolkit for use by primary care practices. Despite the fact that there are not enough geriatricians – medical experts in the care of older people – to care for the growing geriatric population, primary care providers and their healthcare practices can bridge the gap provided they have the necessary tools to do so (American Geriatrics Society, 2019). By teaching primary care practices evidence-based care for the geriatric patient, the Toolkit will aid not just the patient, but society as a whole. Geriatric patients would be cared for in a way that mimics practices of geriatricians, leading to better outcomes as evidenced by patient satisfaction (Totten, Carson, Peterson, 2012).

Because the population of geriatric patients is growing while the number of geriatricians is stagnant, primary care physician practices will need to adapt their services to accommodate elderly patients. According to the National Academy of Sciences, geriatric patients may begin to burden the healthcare system because of their extensive health problems (Totten A., et al., 2012). Deficits in the quality of care of the geriatric patient highlight the need for interventions to improve care. This essay will trace the development of a potential intervention, a toolkit for the improvement of the management of the geriatric patient. of a Geriatric-Friendly Practice Toolkit. The Toolkit is intended to be used by primary care practices to conduct a self-audit with the intent to improve the care of the geriatric patient. The Toolkit is not designed to be a clinical tool to advise physicians. Rather, it is intended to be a wholistic approach that can used by the entire primary care office staff, and covers a range of factors, including clinical, environmental, social, and pharmacological concerns, among others.

1.1 Scope and Focus - The Aging Population of the United States

In the United States, it is estimated that there will be over 98 million adults over the age of 65 by the year 2060. Simultaneously, the population of oldest-old, those older than 85, is expected to be approximately 20 million by 2060 (Mather Jacobsen, & Pollard, 2015). Additionally, the National Institutes of Health's Institute on Aging reports that the age group of 85+ is the fastest growing segment of the population (National Institutes on Aging, 2018). According to the National Academy of Aging, this growing population is likely to live alone and is more likely to live in poverty than the general population (National Academy of Sciences. 2012). In Pittsburgh, over twenty percent of the population is older than the age of 65. (US Census Bureau, 2017).

Almost all older adults have healthcare coverage under Medicare. Some older adults also have access to insurance by former employers. According to the Kaiser Family Foundation approximately 20% of older adults are so-called "dual eligibles," those people who are covered by both Medicare and Medicaid (Kaiser Family Foundation, 2018)

The geriatric population is vulnerable to the same types of noncommunicable diseases that younger Americans are, including cancer, diabetes, heart disease and lung diseases. The risk for most chronic diseases increases with age leaving older people vulnerable to having multiple chronic diseases. Additionally, the risk of dementia, hearing and vision problems, and/or arthritis-related problems increase over time, leading to unique challenges in treating the geriatric population. In response to these challenges, the Jewish Healthcare Foundation (JHF) requested the development of a toolkit to improve the quality of visits by elderly patients with healthcare providers at primary care practices. Out of these efforts the Geriatric-Friendly Practice Toolkit was created.

1.2 Purpose

The goal of this paper is to catalog the process of the formation of the Geriatric-Friendly Practice Toolkit. The author worked with the Senior Connections team at the JHF in order to create the Geriatric-Friendly Practice Toolkit. It was this practicum that spurred the development of the Toolkit framework. The JHF engaged the author as part of an extended MHA practicum to synthesize relevant research, charrette data, advice from practitioners and interviews with elderly patients and develop the Geriatric-Friendly Practice Toolkit. The objective is to explain how the JHF and the author determined the population of interest, how the quality of life of the elderly person is affected by access to high quality medical care, and how the Toolkit is directed at primary care practices.

The first step in determining how to help primary care practices guide their patients in the process of successful aging is to define what successful aging actually means. There is no uniform definition accepted by medical, psychological or social groups. The WHO defines Healthy Aging "as the process of developing and maintaining the functional ability that enables wellbeing in older age" (World Health Organization, 2018). Additionally, organizations supporting the goal of healthy aging do not concur completely in the definition of successful aging, nor do they agree about how to age successfully.

Looking at aging from a medical perspective, successful aging means optimizing life expectancy while minimizing physical and mental deterioration (Rowe & Kahn, 1998). That can be contrasted with the psychosocial theory, which prizes maintenance of mental functioning through life satisfaction and social participation, with physical wellbeing a secondary concern (Baltes, P. & Baltes, M., 1990). Elderly people tend to describe successful aging in terms of mental,

physical, social and financial wellbeing (Sarkisian, C, & Hays, R. 2002). Successful aging, therefore, can be viewed on a continuum, with no exact definition of success or failure.

Ultimately, the objective of the development of a Geriatric-Friendly Practice Toolkit is to enable successful aging of the geriatric patient. The Toolkit was developed with a robust concept of aging where the senior is able to participate actively in all parts of health and life including the physical, mental, and social aspects. With the assistance of their medical provider, the geriatric adult can live a healthy, safe, and engaged life as long as possible.

1.3 JHF Introduction

The Jewish Healthcare Foundation (JHF), located in Pittsburgh PA, is dedicated to the cause of improving the health of those people living in Pittsburgh and the surrounding areas. The JHF is a public charity which operates under the mission of advancing the quality of clinical care while promoting safety, best practices, and efficiency. The JHF devotes time and energy to important healthcare causes. Recently, the JHF recognized that the population of the US, and Pittsburgh in particular, was aging rapidly. Therefore, the JHF developed the Senior Connections Team in 2016. The Senior Connections Team is dedicated to the mission of promoting safety, best practices, and social well-being among the region's older adults. With the goal of helping older adults age well, the Team works to support geriatric-friendly healthcare, along with social supports, nutrition, mental health, and exercise and recreational opportunities.

The Senior Connections Team consists of physical therapists, nurses, pharmacists, nursing home managers, physicians, and student interns, among others. The team was founded with the intent to ensure that the geriatric patient receiving high quality, meaningful care. The Team often

invites consultants as well, from behavioral and geriatric healthcare practices for advice and feedback.

The JHF, recognizing the aging population was increasing while there is a shortage of geriatricians, proposed the development of a program to advise primary care practices to be able to best manage the health of their advanced-age patient through a self-assessment audit. It draws from best practices research, charrettes – a community meeting with key stakeholders – held by the JHF, and extensive interviews of experts in the field of geriatrics.

2.0 Geriatrics Background and Toolkit Purpose

The purpose of the Geriatric-Friendly Practice Toolkit is (1) to support primary care practices in the management of the geriatric patient, (2) to advise how best to adapt the clinical setting to accommodate the patient, (3) to assess for social support or disruption, and (4) how to best manage pharmacological factors for the geriatric patient. The Toolkit, as seen in an abridged format in Addendum 2 to this essay, emphasizes maintaining a line of open communication between the practice and the patient to help manage complex self-care routines, medications, and social issues. The Geriatric-Friendly Practice Toolkit teaches primary care practices the strategies and methods to best accommodate the geriatric patient.

2.1 Pittsburgh Community Needs Assessment

Older patients tend to develop multiple chronic conditions which must be carefully managed by their primary care physician (National Council on Aging, 2019). Occasionally, as the geriatric patient's multiple conditions become difficult to manage, the patient or caregiver chooses to see a geriatrician instead. Pittsburgh has one of the oldest metropolitan counties in the country, according to research conducted by the University of Pittsburgh's Center for Social and Urban Research (Musa, et al., 2014). In Pittsburgh, over twenty percent of the population is older than the age of 65. (US Census Bureau, 2017).

2.2 Shortage of Geriatricians

A geriatrician is a primary care board-certified physician with advanced training in the care of the geriatric population, defined as adults over the age of 65 (Poe, 1975). The purpose of the geriatrician is to provide comprehensive care to the elderly person who often manifests with multiple chronic comorbidities (Sorbero, Saul et al. 2012). These conditions include lifelong diseases, age-related diseases such as arthritis, and often dementia. Geriatricians work to manage the medical conditions the patient has while carefully weighing the need for treatment and more medication. They tend to holistically care for patients, often working with the patient to decrease the use of aggressive treatments (Radcliffe et al, 2011). Healthcare traditionally focuses on curing disease, but geriatricians place the emphasis on quality of life rather than quantity of life (Bates et al, 2019). The geriatrician places an emphasis on symptom management rather than curing disease. For example, the elderly metabolize drugs at a different rate than younger patients do, and can result in side effects such as cognitive impairment (Woodruff, 2017). Approximately 50% of elderly patients are on five or more medications a week (Woodruff, 2017), and patients are often unsure why they are taking the medicines (Shamji et al, 2013). The primary care practitioner can instead place an emphasis on decreasing polypharmacy – the use of multiple drugs to treat one condition. By doing this, side effects such as delirium and falls can be decreased in the geriatric patient (O'Connor et al, 2012).

Currently, the United States is underserved by board-certified geriatricians (Health Resources & Services Administration, 2017). There are approximately 7200 certified geriatricians in the US, and 465 in Pennsylvania as of 2017 (American Board of Medical Specialties, 2016-2017). However, it is estimated that 20,000 geriatricians are currently needed to manage the needs of elderly Americans (American Geriatrics Society, 2019). In Pennsylvania, the number of

geriatricians has fallen in the past 10 years, with an estimated shortfall of over 450 geriatricians (American Geriatrics Society, 2017). The following graph illustrates the deep divide between the number of geriatricians currently practicing and the current need, and demonstrates that in the next five years, the need for geriatricians is only going to accelerate.

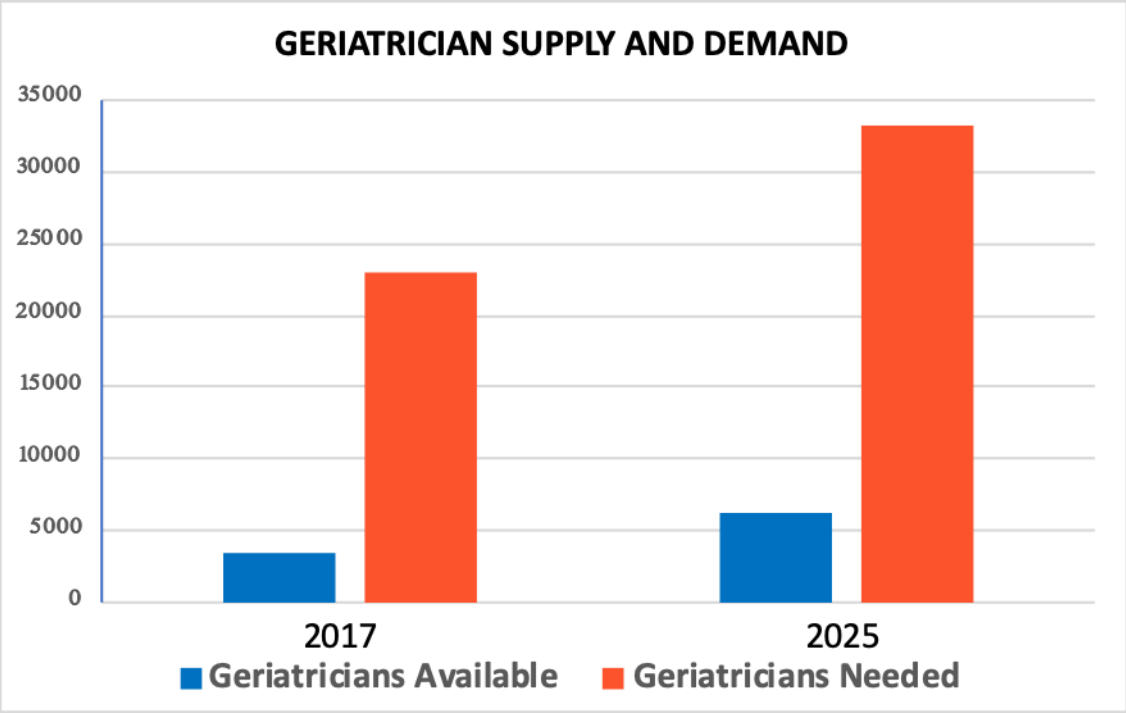

Figure 1: Supply and Demand of Geriatricians in the United States

Not only does the US need more geriatricians, but simultaneously, fewer doctors are training in this field (Health Resources & Services Administration, 2017). Many fellowship positions to train geriatricians go unfilled and the number of programs offering fellowships has dropped by over 20 percent (Bragg, E., et al. 2012). Additionally, while a high income is not necessarily the reason all physicians go into healthcare, geriatricians earn less than any other specialty (Leigh, J. et al. 2012).

2.3 Best Practices for Care of the Geriatric Patient

The Institute for Healthcare Improvement (IHI), spearheading healthcare improvements around the world, has recently organized a campaign to create "Age-Friendly Health Systems" in hospital-based healthcare settings. According to the IHI, elderly adults have more complex needs, but they can be managed well if a health provider or system manage them with intentionality.

The IHI recommends using a "4Ms" method of patient management, which the author incorporated into the Toolkit. The 4Ms include What Matters, Medication, Mentation, and Mobility. What Matters involves ensuring that the care the patient receives is the care the patient wants and needs, taking into consideration the patient's goals. Medication includes ensuring the patient is prescribed and is taking the correct medications, correctly. Mentation is ensuring that the patient is properly screened and treated for dementia, depression and delirium, including assessing medications the patient is taking which could cause delirium. Mobility is ensuring the patient moves safely at home, in the healthcare setting, and out in the community (Institute for Healthcare Improvement, 2019). While there are a number of high-quality organizations providing research into best practices for care of the geriatric patient, the primary source for the Toolkit was the extensive 4Ms research recommended by the IHI, as well as numerous literature sources as noted in this essay.

3.0 Methods

The development of the Geriatric-Friendly Practice Toolkit was informed by multiple data sources including reviewing charrettes, primary research in the form of interviews, and finally prototype development and refinement. It was an interative process of contact development, data-gathering and analysis. Then the author also reviewed literature on the the topics identified from interviews to determine content and structure for the Toolkit which intended to provide direction on improvements to primary care practices. The ultimate goal of the Geriatric-Friendly Practice Toolkit was to help primary care provider practices develop a method of best managing the geriatric patient from start to finish.

In order to assess the community's needs, the JHF hosted a series of geriatric-friendly community meetings called charrettes intended to elucidate problems and map solutions. The charrettes included planning sessions, workshops with wellness and healthcare professionals including physicians, nutritionists and pharmacists. The outcomes from the charrettes were a community needs assessment, which recommended better disease management, information and communication design, improved and integrated use of technology, and quality improvement in doctor's offices.

3.1 Format of a Geriatric-Friendly Practice Resource

Early in the discussions of the development of a geriatric-friendly resource for primary care providers, numerous ideas were considered including a website, a newsletter, and/or an

educational conference. During discussions with experts within the JHF in the field of geriatrics on the Senior Connections Team, pros and cons of the various methods of information delivery were discussed. The idea of a website or newsletter was deemed infeasible, because the JHF does not have the staff to develop or maintain either.

Ultimately, the Senior Connections Team and the author landed on the idea of a Geriatric-Friendly Practice Toolkit. The Toolkit would be a permanent resource for the Senior Connections Team to draw from on a regular basis. From the Toolkit, an online dashboard could be created in the future if there was demand for it. Additionally, it was decided that a newsletter containing information from segments of the Toolkit could be developed for distribution without requiring undue staff effort.

3.2 Charrettes

The first stage of development of the Toolkit was to review transcripts and notes from the charrettes the JHF hosted. Approximately five charrettes held over the course of a year with around 50 thought leaders in the area of geriatrics were very valuable. The charrettes were half-day, intense thought-exercises involving many interdisciplinary experts. Held at the JHF, the charrettes were attended by a wide range of people including the elderly, primary care practitioners, geriatricians, office managers, nurses specializing in geriatrics, and nutritionists, business owners, etc.

The charrettes produced robust information regarding community and patient needs. One of the issues brought up during sessions included the concern that the geriatric population feels their healthcare needs are not being met. Another concern was the problems elderly patients face

in visiting their provider. These ran the gamut from access to transportation, ease of making appointments, issues with accessibility of providers, and communication. During the charrettes, specific concerns were raised, such as calling to make the appointment, getting to the practice's office, the visiting with the practitioner, to obtaining results and treatment plans, making follow-up appointments, etc. Another important topic addressed was the discussion end-of-life (EOL) care with patients and whether EOL planning is something that elderly patients want to discuss. During the development of the Geriatric-Friendly Practice Toolkit, many concerns and questions raised during the charrettes were incorporated into the development of the toolkit. Many concerns were systemic in nature and challenging to addresses on an individual or practice-level, but all are important for primary care practices to consider.

The charrettes generated many topics for the author to research for best practices, including transportation, access, communication, and end of life care. There is a dearth of information in the literature to support best practices around many of the topics including how to broach end of life discussions with patients, how to manage polypharmacy, how to incorporate families in visits with geriatric patients, etc. Some topics to consider were widespread use of tech which many elderly people are not comfortable with, both mental and physical health goals for the patient, layout of the provider practice, and discussion of end of life goals.

3.3 Research

During the research phase of the Toolkit development, the author found dozens of journal articles detailing how best to work with the geriatric patient in a hospital setting. There is plenty of research on the experiences of geriatric patients during a hospitalization or emergency

department visit (Lavizzo-Mourey, n.d., Radcliffe et al, 2011, Sorbero et al, 2012, Totten et al, 2012), but very little has been researched about the outpatient setting. Therefore, the author interviewed practice managers, pharmacists, providers, patients, and ancillary office staff to assess their vision of the ideal format of a primary care practice for a geriatric patient. The author used a semi-structured interview process, using a set list of questions and then developing further questions as topics were discussed. Most of the interviews lasted for 30 minutes, and the author took notes during the interview and debriefed after the sessions. The interviewees were recruited based on people the author knew personally, and employees of the JHF. Based on the literature and research available, there is ample room for improvement in the field of geriatric-friendly health practices.

3.3.1 Scheduling

The first issue uncovered during charrettes was the substantial challenges patients face scheduling medical appointments. According to patients the author interviewed, it is important for patients to feel comfortable scheduling appointments to visit the provider. Many elderly patients stated that they were not tech-savvy and felt uncomfortable scheduling an appointment on a website, according to the University of Michigan's National Poll on Healthy Aging **(**Malani et al, 2019). Fewer than half of all patients over age 50 have set up a "patient portal" their providers may offer (Malani et al, 2019). The older adult may even find an automated phone system challenging to use. Having an option to stay on the line or press '0' to reach an operator would be preferred, because then the patient can reach a human to help them schedule. If a medical practice uses an online- or app-based scheduling system, consider having a phone system for those unable to access the internet.

3.3.2 Transportation

Not all seniors are comfortable driving, and public transportation can be difficult to navigate. A patient missing an appointment due to unreliable transportation can have their quality of care negatively affected. Although resources like Access, a free driving service that picks patients up from their residence, are available, they can be challenging for older adults to schedule because pick-ups cannot be made the same day (ACCESS, 2017). One thing that can be done for patients to help with transportation concerns is to prepare a list of resources to offer to enable patient to get to appointments. These could include Access, Uber, Lyft, etc. There are numerous transportation solutions available to patients which may help with reducing readmissions and making sure patients get to their appointments, but many patients need help arranging the transportation. Lyft, Uber and other ridesharing companies are able to provide rides to patients, which can sometimes be billed to Medicare or Medicaid. In addition, some ride-sharing services now allow external sources to schedule rides, which eliminates the need for "smartphone" technology. Practices could consider training staff to offer to schedule ridesharing for the patient.

3.3.3 Waiting Rooms

Waiting room accessibility is important to consider as well. Older adults often lack the muscle tone to rise out of deep chairs. Chairs that are easy to sit on and rise out of, make for a more comfortable visit. Chairs that have arms on both sides are much easier to push out of. Practices can make simple changes such as attaching cane clip holders to chairs so that canes remain in easy grasp instead of falling to floor. Additionally, older adults come in a variety of

sizes, so chairs that are extra wide and chairs that are of varied heights are appreciated by patients. Long waits in uncomfortable chairs can increase discomfort.

Geriatric patients have different needs and deficits than a younger patient population. Incontinence can be a distressing issue for the geriatric population, so an easily accessible bathroom is important. Bathrooms should be ADA compliant, and have handrails next to and behind the toilet so that patients with mobility issues can more easily access the toilets. Likewise, hearing loss is common in the elderly patient. The need for a television in the waiting room is almost completely unnecessary in our digital era. For someone hard of hearing or with dementia, the distraction of the television may be overwhelming. Primary care practices can accommodate the elderly by turning down the volume and having subtitles on. In a large practice, the television could be converted to a digital wait time board and a "now calling" feature so that patients can clearly see who is being called back.

3.3.4 Primary Care Team

Ideally, a primary care practice team should have the ability to jointly come together at the patient's intake appointment. The team should consist of a social worker, a physician or nurse practitioner, and patient caregiver (if necessary), in order to establish a comprehensive baseline assessment of the patient. Following this appointment, a larger interdisciplinary team including the primary care practitioner, pharmacist, and community-based social support can convene, if necessary, to develop a plan of care for the patient. Thoughtful collaboration can ensure common geriatric problems are effectively managed while supporting the patient's stated goals. Multidisciplinary teams doing coordinated care help to prevent readmissions and can play a critical part in helping reduce the 17-billion-dollar price tag that comes with avoidable hospital

readmissions (Lavizzo-Mourey, R. 2013). Hospitals are working to reduce this cost and can be important teammates in the care of patients. Patients aren't just returning to the hospital because they are sick. They also return due to housing instability, food insecurity, and transportation challenges, among others. Coordinated primary care practices with robust referral networks can act as a lynchpin in the prevention of readmissions.

3.4 Interviews with Outpatient Office Staff

In the course of the MHA practicum, the author spoke with practice managers, pharmacists, providers, ancillary office staff and patients to assess their views on needs of the geriatric patient. Each professional had their own recommendations to improve care for geriatric patients. The practice manager the author spoke to had a key concern which was preventing the patient from slipping through the cracks after their appointments. They suggested utilizing medical assistants (MAs) and nurses to help with this. The nurses would be responsible for ensuring patients understand their care plan upon discharge and understand any medication changes. Additionally, nurses would be responsible for calling geriatric patients the day after appointments to ensure that medications have been refilled and that patients still understand the plan for them. MAs would be responsible for ensuring patients have follow up appointments scheduled and have rides to get to the appointment. Pharmacists proposed that patients bring in their medications to all appointments, called "brown bagging," to ensure that the providers know all the medications the patients are taking. This can help ensure the patient is not duplicating types of medication, which can cause symptoms such as low blood pressure, confusion or delirium (Woodruff, K., 2017). Pharmacists also recommended primary care providers emphasize to the geriatric patient that pharmacists are

good resources in the event the patient has questions about their medications. The two geriatricians were naturally most concerned with the health of the patient. They brought up the concept of palliative care, which is providing the most effective care for the patient without the express goal of curing the patient. Additionally, providers mentioned the importance of patients having end of life care discussions with family members and having a medical power of attorney.

3.5 Envisioning the Perfect Geriatric Outpatient Experience

Next, the author envisioned the patient experience of a doctor visit from creation of the appointment to the office visit to the return home. Taking into account research such as the 4Ms, the results from the charrettes and discussions with key stakeholders, the JHF and the author envision a "perfect" geriatric patient experience. Using this schematic as a conceptual template for a theoretical perfect experience as well as the results from research and interviews, the author developed the Geriatric-Friendly Practice Toolkit.

As can be seen in the cartoon depiction (Fig 1), the patient, Joe, lives in the community and has his Community Health Worker (CHW) Sarah visit him to develop appointment plans and goals. Joe has his travel plans coordinated for him, and gets to his primary care practice with ease. At the office, Joe's needs are addressed so that he is as comfortable as possible. During the appointment, Joe's care team collaborates with him to develop the plan of action that best suits Joe's goals. After the visit with his provider, Joe visits the pharmacist who educates Joe on new medications, reviews current ones, and ensures Joe understands his medication regimen. Joe's ride is waiting for Joe to take him back home, and once home, his CHW visits shortly after the visit to ensure Joe understands the plan of action for his care.

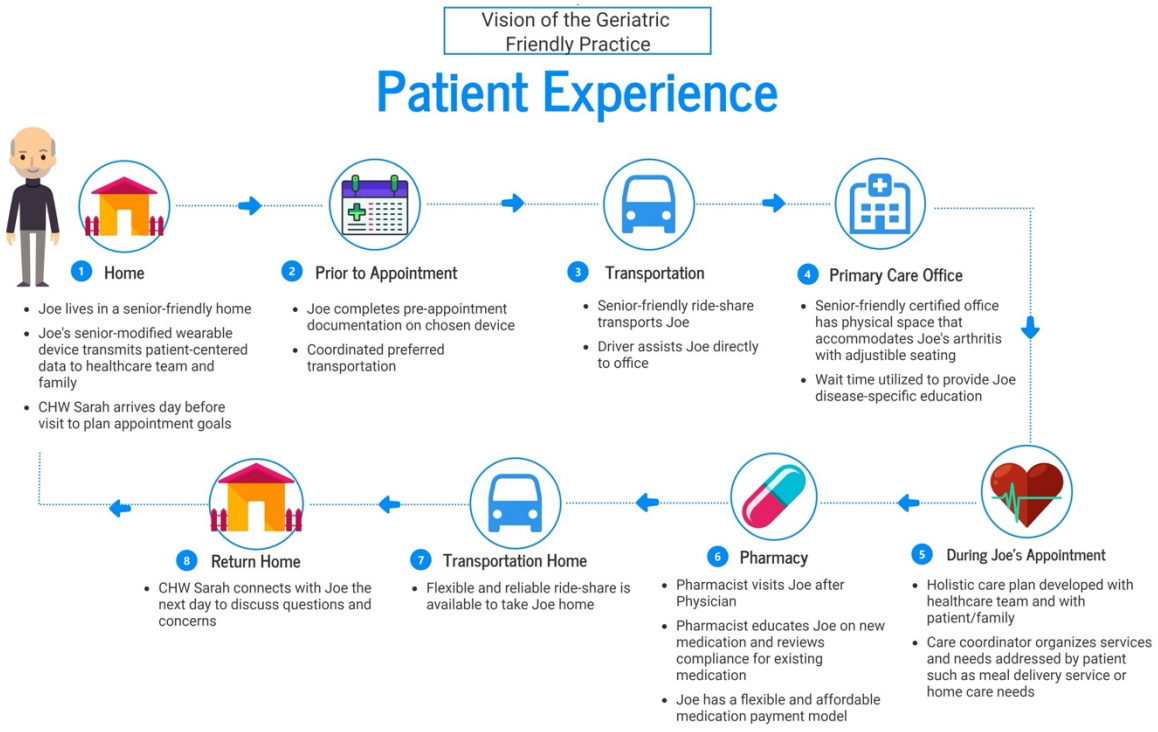

Figure 2: Vision of the Geriatric Friendly Practice Patient Experience

Used with permission from JHF.

4.0 Geriatric-Friendly Practice Toolkit

The Geriatric-Friendly Practice Toolkit, as seen in an abridged version in the appendix to this essay, is a document intended to be provided to primary care practice managers to enable them to evaluate their capacity to effectively care for the geriatric patient population. The Toolkit is in this abridged format due to proprietary restrictions on the document. In the toolkit, there are many recommendations for improvements and explanations of how to efficiently care for the geriatric patient. The Geriatric-Friendly Practice Toolkit consists a list of questions, reasoning behind the questions, and ways to affect positive healthcare changes for older adults who visit primary care practice offices. The objective of this Toolkit is to optimize primary health care for older residents of Allegheny County, and ultimately for all seniors. Eventually, the goal is that any primary care practice using this Toolkit will successfully meet the needs of the elderly patient, through physical, social, societal, and medical support systems.

The use of the Toolkit could allow a primary care practice to provide the best possible healthcare to the geriatric patient. The Geriatric-Friendly Practice Toolkit can be employed to holistically teach the entire Primary Care Practice staff how to best manage the health and care of the geriatric patient. By developing this Geriatric-Friendly Practice Toolkit, the author and the JHF intended for healthcare practices to develop tools of their own which they could use to improve the health of the geriatric patient.

In the Toolkit, questions, answers, and explanations are presented, with the goal of educating primary care practices, including practice managers and front-line staff and providers, about the needs of elderly patients. The intent is to provide guidance to make primary health care more responsive to needs of seniors. The Toolkit also contains advice and practical guidance to

show that normal, age-related changes can be managed so that the elderly person can live a healthy and productive life. The goal of using the Toolkit is to develop a primary care practice that integrates community-based supports and services across the population of older patients to foster better patient care and coordination.

4.1 Overview of Document

The intent of the Geriatric-Friendly Practice Toolkit is not to replace geriatricians, as their knowledge is irreplaceable and invaluable. Instead, the goal is to enhance the care provided to the geriatric patient by Primary Care Practices such that the geriatric patient is well cared for and their needs are fully met. Primary care practices can provide the geriatric patient with a safe, welcoming environment where the patient's quality of life is prioritized.

1. **Home** – oriented toward the patient living at home, remaining at home, and transitioning back to home after hospitalization.
2. **Customer Service** – including quality improvement methodology, including workflow assessment and workflow redesign, coordinated care management, and physical plant layout
3. **Provider/Medications** – focusing on the role of the various providers within the practice and the medications the patients are taking
4. **Care Plan** – including coordinated care management
5. **Health of the Geriatric Patient** – ensuring patients get the best care possible using the most up-to-date resources and research
6. **Patient Goals/End of Life** – conversations about palliative care and end of life

7. **Technology** – addresses technology used in the primary care office as well as technology the patient uses
8. **Patient and their Caregiver/Family** – How to incorporate family into care of the geriatric patient

4.2 Toolkit Implementation

The fully developed Toolkit will be provided to primary care provider practices along with educational workshops provided at physician gatherings to teach them about the benefits of the Geriatric-Friendly Practice Toolkit. Prior to rolling out the Toolkit to the community at large, the JHF plans to pilot it to interested primary care practices in the Pittsburgh community. See addendum 1. By piloting the Toolkit at interested practices, the JHF can revise necessary sections.

Subsequently, any interested practices will receive more extensive training sessions to teach about specific goals and opportunities when they implement this program. The JHF will provide an online discussion board providing advice and resources to practices. Additionally, this online site will allow practices to be sounding boards to each other when questions arise. The JHF will actively work to recruit training experts, those "early adopters" of the Geriatric-Friendly Practice Toolkit, who can act as community champions to encourage other practices to adopt the Toolkit. JHF will provide occasional lectures on certain topics in the realm of the Toolkit, which include education on housing, nutrition, mental health, and primary care practice redesign. Another role the JHF has agreed to take on is to identify community resources for primary care offices to improve patient health. These include resources for seniors to maintain living within the

community, via exercise, home health visits, etc. Additionally, the JHF will leverage community support through congregation sites such as senior apartment complexes, senior day centers, and religious institutions.

The Toolkit includes questions directed at the primary care practice manager, the providers, as well as the patient and their families. To best use this Toolkit, the practice manager should read through the questions while asking if they do this for their older adult patients in a well-coordinated and thorough manner. The logic behind the questions is explained, as well as guidance provided to improve the practice either in the short or the long-term. In a geriatric-friendly healthcare system, the goal is to avoid unnecessary hospitalizations, prevent adverse events, and promote senior wellbeing and independence. While it may seem challenging to implement, the practice is encouraged take small incremental steps toward improvement, and remember: the ultimate outcome is healthier patients who are more engaged in their communities and their own health.

4.3 Toolkit Use

The Geriatric-Friendly Practice Toolkit is specifically directed toward use by the office manager and the office providers. The hope is that the primary care practice employees will be willing to engage with the Toolkit in order to create a geriatric-friendly office for their patients. The recommendation for using the Geriatric-Friendly Practice Toolkit is to review the topics and then pick an area or two which may be easy for the practice to affect some fast fixes or "easy wins." As the practice progresses within or throughout the sections, the practice could consider doing some more of the challenging readjustments if they are feasible. Alternatively, if the practice is considering doing major remodeling in the near future, the Toolkit would enable the practice to

figure out which areas need the most retooling and use the recommendations to direct them in the renovation. The purpose of the toolkit is to provide guidance to the practice to achieve the goal of being responsive to needs of seniors.

By ensuring that the geriatric population receives the best possible care within their primary care practices, hospital admissions can be prevented, falls decreased, functional declines are detected and remediated more rapidly. The Toolkit can also help prevent nursing home placement by helping to ensure the patient remains at home as long and as safely as possible. In assessing seniors' needs, it is important to be sure that their autonomy, choice, and dignity are respected. By being mindful of the requirements of the geriatric patient, it may be possible to help decrease the rate of nursing home admissions by ensuring the geriatric patient remains in the best environment possible for their well-being for as long as possible.

5.0 Limitations

There are a number of limitations with the Toolkit. The first and most critical limitation that the author has identified is that cost may be a large concern to small Primary Care Practices. Primary Care Practices will need to be deeply committed to improving the health of older adults, with little regard for cost, if they can afford to do so. The Geriatric-Friendly Practice Toolkit implementation could be perceived as expensive to implement because it suggests undertaking significant practice modifications. Additional salaries for adding employees, as well as improving office amenities, may be a hinderance to creating a geriatric-friendly environment.

Another important limitation to consider is that the Geriatric-Friendly Practice Toolkit implementation is a difficult job for busy practices to undertake. To fully implement the Toolkit will take hours of the practice manager and staff time. In the current state of healthcare, staff is strapped for time, and are often running at maximum capacity. This means that the office would likely have to hire someone to implement the Toolkit, add the responsibility to someone within the practice, or alternatively, employ the JHF to work as a consultant with the practice. Again, this is costly to the primary care practice.

A third limitation in implementing the Geriatric-Friendly Practice Toolkit is that there must be metrics developed in order to measure success. These would include surveys, patient satisfaction, return visits as well as provider and office staff satisfaction. Presently there are no metrics established to measure the success of the implementation. The author recommends implementing metrics in order to assess if the Toolkit improves health, longevity, safety or satisfaction of the geriatric patient.

6.0 Conclusions

The primary care system is charged with caring for all patients, young and old. In the United States, care of the geriatric population is an important and necessary part of public health. By maintaining and or improving the health of the geriatric population, we may be able to lessen some of the heavy demands they place on the healthcare system. We know from literature that there are positive outcomes when the geriatric patient is cared for by professionals who are well prepared and educated in the care of the elderly patient (Totten, A. et al. 2012) including lower rates of nursing home admissions, better nutrition, lower rates of depression and higher rates of patient satisfaction with the care they receive (Radcliffe, et al, 2011). Providing tools to primary care practices to foster better care of the geriatric patient is one way to address the geriatrician shortage. The ultimate goal is to ensure that the geriatric patient receives patient-centered care in collaboration with the patient's primary care practitioners, which provides benefits not only to the geriatric patient, but also to society. Healthier patients can promote economic stability by lowering the number of ER visits and inpatient hospitalizations. Excellence in geriatric care helps to achieve the IHI's 4 M's goal, which at its core is intended to improve the lives of geriatric patients.

The ratio of geriatricians to elderly has fallen significantly, indicating a serious erosion of capacity in the health system. This opens the door to other providers, such as internists and primary care practitioners to fill in the gaps. This means that practices serving traditionally younger populations will need to adapt their services to meet the needs of the geriatric population. In order to accommodate the geriatric patient, primary care practices will need to adapt to become capable of managing the complex health and physical needs of the elderly population. These requirements should be assessed on an ongoing basis, whether it is about how to remain engaged in the

community, to take up a new exercise regimen, to consider how aggressively they wish to be treated for their conditions, or to discuss end of life planning, etc.

By ensuring that the geriatric population receives care at a primary care practice which has gone through the Geriatric Friendly Toolkit, patient needs can be served, and functional declines identified and remediated more rapidly. In assessing seniors' needs, it is important to be sure that their autonomy, choice, and dignity are respected. By being attentive to the distinct healthcare requirements of the geriatric patient, primary care practices can be instrumental in helping their patients safely remain in the best environment for their well-being, for as long as possible.

Appendix A: Primary Care Practice Target Letter

First Addendum 1:

Dear Primary Care Practice Manager –

The Jewish Healthcare Foundation is creating a Geriatric-Friendly Practice Toolkit for use in a primary care practice setting. The objective of this Toolkit is to optimize primary health care for older adults. The Geriatric-Friendly Practice Toolkit includes a list of questions, reasoning, and ways to effect change that can in the future be provided to Primary Care Practice offices.

Since your practice works with seniors regularly, we are interested in introducing this draft Toolkit to you to gain your feedback. This would be an informational session with you or you and your staff regarding your current practices and understanding of the senior population in our area. Please email us back at your convenience

This session will help the Jewish Healthcare Foundation build a more robust and thorough Toolkit, which in turn will help practices become more geriatric-friendly. Thank you for your time and we are looking forward to working together.

Please let us know if one of the two following times is available for you to meet with us for about 90 minutes in a collaborative meeting with other primary care practices at the JHF offices in downtown Pittsburgh.

Sincerely,

Senior Connections Team,

Jewish Healthcare Foundation

Targeting interested primary care practices in the Pittsburgh region.

Appendix B: Geriatric Friendly Practice Toolkit for PCP Practices

Overview

Here is what we know: A Silver Tsunami is coming! A growing population of seniors, almost all with multiple chronic conditions, will require different health care and high levels of support if they are to live well and safely in their communities.

One of the Jewish Healthcare Foundation's aims is to encourage primary care practices to gracefully address the needs of the rapidly growing, diverse range of older adults, some of whom are thriving, while others are frail. A majority of older adults wish to remain integrated at home, many want to contribute in a meaningful way to their community or even to remain employed as long as possible. Numerous studies show that when older adults feel purposeful, they live longer healthier lives and have better health outcomes.

We know we do not have enough geriatricians to manage this increased volume of older adults, so we must support current health care practices in providing the best care to their patients. There are currently approximately 7000 certified geriatricians in the US, and about 450 in Pennsylvania. However, it is estimated that 20,000 geriatricians are currently needed to manage the needs of elderly Americans. To that end, the JHF has created a Geriatric Friendly Practice (GFP) Toolkit for use by primary care practices. The GFP is an instrument intended to compliment the current approach and procedures that PCP practices already use when caring for the older adult population. This Toolkit was created from the illuminating results after a conference that the JHF held, bringing together a diverse set of members of the community, from older adults to primary care practices, caregivers to employers.

The GFP will be provided to Primary Care Practice (PCP) offices, with the intent of the optimization of primary health care for older adults over the age of 65. Our hope is that PCP practices using this Toolkit will be able to successfully meet the needs of the older adult patient, through physical, social, societal, and medical support systems. The Toolkit is intended to be used as a self-assessment, rich with questions, explanations, and recommendations, to help practices identify areas they are doing well alongside areas they can target for improvement.

In order to accommodate the growing population of older adults in the primary care sphere, practices will eventually need to become capable of handling the complex health and physical needs of the population of older adults. The unique needs of this population should ideally be assessed on an ongoing basis, whether it is about how to remain engaged in the community, take up a new exercise regimen, or how aggressively they wish to be treated for their conditions. By serving the needs of this dynamic population, JHF anticipates being able to reduce costs associated with health care by keeping them healthy and in a safe environment for as long as possible. Older adults should be able to remain in their homes and out of the hospital as much as possible. As the well-known adage goes, "an ounce of prevention is worth a pound of cure".

Recommendation for Use

Our recommendation for using this Toolkit is to look through the topics and then pick an area or two which may be easy for you to put in some fast fixes. As you progress within or throughout the sections, consider doing some of the more of the challenging readjustments if they are feasible. Alternatively, if you are looking to do some major restructuring in the near future, figure out which areas your practice needs the most retooling, and use our recommendations to direct you in your implementation. Our goal is to provide guidance to you to achieve your goal of

being responsive to needs of seniors. There is no wrong way to approach your investment in the health of the older adult population!

In this Toolkit, we present topics outlining "best practice" in order to educate PCP offices, including practice managers and front-line staff, about needs of elderly patients. The Toolkit also contains advice and teaching to show that normal, age-related changes can be managed so that the elderly person can live their best healthy and productive life. In using the Toolkit, JHF hopes that you will create a practice that integrates community-based supports and services across the population of older patients to allow for better patient care and coordination.

The audit includes questions directed at the PCP practice manager, physicians and other providers, and there is a section specifically for patients and their families as well. The logic behind the questions is explained, as well as guidance provided to improve the practice either in the short or the long-term. In a senior friendly healthcare system, the goal is to avoid unnecessary hospitalizations, prevent adverse events, and promote senior wellbeing and independence. While it may seem challenging or overwhelming at first to implement, take small incremental steps toward improvement, and remember: the ultimate outcome is healthier patients who are more engaged in their communities and their own health.

If we can ensure that seniors receive the best possible care within their primary care practices, we can help prevent hospital admissions, falls, detect and remediate functional declines more rapidly. This can help prevent hospital admissions and nursing home placement. In assessing seniors' needs, we need to be sure that we are respecting their autonomy, choice, and dignity in the process. By being mindful of the needs of the geriatric patient, we can ensure they remain in the best environment possible for their wellbeing, for as long as possible.

Geriatric Friendly Practice Toolkit

Selected Sections:

9. **Home -** Oriented toward the patient living at home, remaining at home, and transitioning back to home after hospitalization

10. **Customer Service** - including quality improvement methodology, including workflow assessment and workflow redesign, coordinated care management, and physical plant layout

11. **Provider/Medications**

12. **Care Plan** - including coordinated care management

1 – Home - Oriented toward the patient living at home, remaining at home, and transitioning back to home after hospitalization

How can we engage with the patient from home to practice and back?

Are we ensuring the patient can easily make an appointment to come visit our practice? The concern is, many seniors are not as tech-savvy as younger patients. The older adult may find an online scheduling system or even an automated phone system challenging to use. If you use a phone system, having an option to stay on the line or press '0' to reach an operator would be preferred. If you have a mostly online-based scheduling system, consider having a phone system for those unable to access the internet.

Are a variety of appointment times to patients when scheduling a visit? A flexible array of appointment times can help the patients avoid missed meals and may enable caregivers or family members to attend the appointment without losing valuable work time. Work with seniors to schedule appointments at appropriate times. We should ask our patient what times are best for them instead of telling them when the next available appointment will be. Additionally, in our patients identified as having some memory loss or dementia, it is best to encourage the patient to include a caregiver or family member at the appointment to ensure continuity of care.

If possible, can we accommodate opportunity for patient to have telemedicine appointments instead of coming into the office? Some of the benefits of telemedicine includes ability to remotely assess patients to avoid hospitalizations and limit emergency room visits, can reduce stress on caregivers, can help patients who are homebound or who have mobility limitations, or those who have problems getting to the practice because of transportation issues. When patients call for a same day appointment, assess if patients have access through Medicare to telemedicine. Additionally, we can remind patients during regular visits that telemedicine can be an option for them to help avoid heading to the ER.

How can we make it easy for the patient to communicate with the practice from home? Communication with the practice can ease the concerns of the patient. This communication can come in different formats, including phone calls, online portals, and text messages. Giving our patients access to medical records online can reduce costs associated with repeated tests. During visits to the practice, can we take the time to remind the patient and family or caregiver how to access medical records online? If patient is unsure how to access information, do we have a staff member who can act as the "online portal" coach to teach patient.

As a practice, do we have the ability to jointly come together at the intake appointment with the patient and support team, which ideally consist of a social worker, a physician or nurse practitioner, and patient caregiver (if necessary), in order to establish a comprehensive baseline assessment of the patient?

Following this meeting, a larger interdisciplinary team including PCP, pharmacist, and community based social support can convene if necessary to develop a plan of action. Through collaboration, we can ensure we are managing the common geriatric problems while supporting the patient's stated goals.

Are we able to actively support initiatives to keep seniors in their homes and remaining within their community? Can we address some of their needs or connect them to the right people when it comes to community resources, access to food, loneliness/depression? Do we know of services in place if they have difficulty walking? Difficulty purchasing groceries? Aging in place has been shown to reduce costs by up to $20,000 per year for elderly who want to stay at home, as compared to those in nursing homes. Is it possible for us to put together a robust list of community resources for seniors?

Resources can include, but are not limited to:
Home Instead
Comfort Keepers
Meals on Wheels (and other meal delivery services not associated with lower income seniors)
Grocery delivery

As a practice, are we able to develop a robust referral network, such as referral to home support, food/nutrition, getting to appointments, community outreach organizations, and senior centers? There are many organizations who have collected this information as a useful resource.

Do we take the time to discuss physical safety in the home with our patients? Keeping seniors safe in their home keeps costs down and maintains quality of life. Suggest that patients get rid of throw rugs, have bath bars, and toilet bars installed. Ensure that there are non-slip surfaces in wet areas of the home. Advise those at high risk for falls to consider wearing a personal alert button.

Assess if patient is living alone and has suitable personal and community support.

Do we have someone at the practice designated to call patients the day after discharge from a hospitalization and schedule a follow-up appointment?

The post-hospital experience has often been viewed by patients as extremely unpleasant. Many people feel that they are dumped out after an inpatient stay with no follow up or support. Patients feel best if they receive a follow up call from their provider the day after discharge. Providing answers to questions and scheduling a post-admission primary care visit helps to prevent readmissions and keeps patients from "slipping through the cracks in the system". The appointment with the provider is a critical step in reducing the nearly 20% readmission rate after hospitalization.

Does the practice have a robust network providing coordinated care?

Multidisciplinary teams doing coordinated care help to prevent readmissions, and can play a critical part in helping reduce the 17 billion dollar price tag that comes with avoidable hospital readmissions. Hospitals are working to reduce this cost, and can be important teammates in the care of your patients. Patients aren't just returning to the hospital because they are sick. They also return due to housing instability, food insecurity, and transportation challenges, among others. As you become a coordinated practice with robust referral networks, your practice will be a lynchpin in the prevention of readmissions.

The Care Transitions Program is an excellent online resource for families and caregivers of patients. The site also has resources for healthcare providers. https://caretransitions.org

There are numerous transportation solutions available to patients which may help with reducing readmissions and ensuring patients get to their appointments. Lyft, Uber and other ridesharing companies are able to provide rides to patients, which can sometimes be billed to Medicare or Medicaid.

Have we developed resources for transportation for our patients to come to and leave our practice? Not all seniors are comfortable driving, and public transportation can be difficult to navigate. If the patient misses an appointment due to unreliable transportation, it can negatively affect quality of care. Additionally, resources like Access are available for transportation, but can be challenging for older adults to navigate. Some things we can do for our patients is prepare a list of resources to offer to enable patient to get to appointments. These could include Access, Uber, Lyft, etc. Some ride-sharing services now allow external sources to schedule rides, which eliminates the need for "smartphone" technology. Consider training staff to offer to schedule ride-sharing for patient.

How flexible is the transportation that patients have to the appointments we are offering?

It's not unheard of for providers to run late, which could cause anxiety to the patient that they could miss their ride. If we can ensure that transportation is flexible, that the driver will not leave prior to the patient having enough time with our providers, that will help to reassure the patient that they will be able to spend enough time to address their concerns with the provider. Office staff could schedule a ride home for the patient with a ride hailing service, sometimes covered under Medicare/Medicaid, or alternatively, staff at the practice can call the patient's scheduled transportation to give an update if appointment is running long.

2 – Customer Service - including quality improvement methodology, coordinated care management, office accessibility

Customer service, which includes quality improvement, care management, and even office accessibility is a broad and extensive topic. Be sure to pick the sections that work best for you in your office. Do not get overwhelmed and feel that you need to fix everything at once. This is a topic best taken in bite-size pieces.

*Are we regularly make a **reminder call** prior to the patient's appointment?* Making a call can help reduce no-show rates by upwards of 50% and can help prevent the patients from inadvertently missing appointments because they forgot. Unfortunately, no-shows, or missed appointments, are a problem for many medical practices. They result in fragmented care and reduce access for all patients. One option is to employ either a robo-call system or have a patient service coordinator make a phone call to patients one or two days prior to appointment. A benefit is that decreasing no-shows increases reimbursements.

Do we have a plan in place to get patients to our practice for their appointment? A small subset of our patients may have been identified as having **dementia** or as needing a ride to and from the practice. This may include a phone call to prompt them on the day of the scheduled appointment, or it may be as involved as scheduling a pick-up time for them? In the event of this type of occurrence, is my front office staff aware of these special needs patients, and are they able to make a phone call to remind the patient that they have an appointment at the practice at a certain time on that day?

Checking In

When the patient checks in for their appointment, are we making them feel welcome?

Ideally, there is no glass partition between the patient and front office staff. Glass partitions can feel unwelcoming and the patient may be uncertain if the office knows they have arrived. When possible, we should greet every patient, preferably by name, when they enter the office.

Take a look at our sign in process when patients arrive.

Is this device or sign-in method user friendly for someone with limited vision or for those with functional issues, such as decreased fine motor skills? Is the sign in method user friendly to someone technology naïve? For someone uncomfortable with the latest and greatest technology, they may not understand how the sign in process works. Try to ensure that every patient who enters the office is greeted by staff and directed to sign in. We can ask patients if they are comfortable using the available sign in method. If they are not, offer to assist them. Additionally, it is best practice to ensure that all print and digital material is in a font easy to read and large enough to read for older eyes; 12-14 point font is considered ideal, Helvetica or Arial are recommended.

Are we having our patients stand for long durations while they check into our department?

During the check in process, having a chair available for the patient to sit is preferred. Some patients cannot stand for long durations, which makes waiting in a line to check-in difficult for them. Consider placing a chair near the check-in desk for the comfort of your patients. Assess whether the check in desk is at an acceptable height for someone with stooped posture or who uses a wheelchair.

Can the older adult hear our staff during their visit?

When the patient cannot hear what the office staff member is saying, this can lead to frustration or even result in a missed appointment, and lost revenue for our office. The patient with hearing loss may need office staff to speak with a lower tone of voice or slower speech. By training staff to use the bottom of their speech register, it will eliminate the need to yell or speak very loudly. Looking toward the future, consider renovations which could dampen sound, as busy practices can get loud, and those who are hard of hearing may have difficulty tuning out ambient noise. Additionally, ambient background noise, such as televisions or radio could be easily eliminated. In the era of digital devices, the need for a wall television is almost completely unnecessary.

Is the waiting room comfortable and accessible for the older adult?

Older adults often lack the muscle tone to rise out of deep chairs. Chairs that are easy to sit on and rise out of make for a more comfortable visit. Chairs that have arms on both sides are much easier to push out of. Consider attaching cane clip holders to chairs so that canes remain in easy grasp instead of falling to floor. Additionally, older adults come in a variety of sizes, so chairs that are extra wide and chairs that are of varied heights are appreciated by patients. Long waits in uncomfortable chairs can increase discomfort.

Take a look at how staff calls patients to the exam room.

Hard of hearing patients or patients with dementia may not notice their name being called, especially in a large or very busy practice. Encourage staff to try to identify the patient prior to calling for them. Optionally, especially in large practices, install a board with updated estimated wait times and "now calling" features so that patients can clearly see who is being called back.

Does our waiting room have an easily accessible bathroom?

Incontinence can be a distressing issue for the senior population, so an easily accessible bathroom is appreciated. Are signs easily identifiable and legible directing patients to the bathroom? The bathroom should be ADA compliant, and have handrails next to and behind the toilet so that patients with mobility issues are comfortable. Ensure that the bathroom is stocked with enough supplies such as toilet paper, soap, and paper towels. If our restroom is immediately within the waiting room, a longer term goal could be to look at renovating so that a restroom is nearby and accessible for those who need it close.

Does the waiting room have a television playing loudly in the background?

The need for a television is almost completely unnecessary in our digital era. For someone hard of hearing or with dementia, the distraction of the television may be overwhelming. Consider removing television or turning down the volume and having subtitles on. In a large practice, you could install a board with estimated wait time and a "now calling" feature so that patients can clearly see who is being called back.

3 – Provider and Medication/Pharmacy

It is our hope that you will use this section to refresh your competencies when working with the senior population. Because older adults frequently have multiple comorbidities, reviewing their patient chart and any written or oral updates provided by the patient at the beginning of the visit allows you to be well versed in their health history. By understanding the patient's history prior to walking into the exam room, the patient will feel as though they are important to you and that you care about them. In the healthcare setting, it is imperative to ensure that the older adult has care that is optimized for them, is value driven, and critically, does not cause them harm.

Some additional considerations during the appointment:

Am I speaking to the patient in a tone and volume of voice that feels welcoming? Seniors do not want to feel like they're being yelled at. By using a low toned, slightly slowed speech pattern, we can eliminate the need to yell or speak loudly.

Do you get the sense that your patient feels they have enough time to ask questions during their visit? A rushed patient can feel anxious, which may cause a spike in their blood pressure, and could cause them to forget questions they may have. The patient should feel as though there is adequate time to get to the exam room, to ask questions, to understand the care plan, to leave the exam room, and additionally, to exit the building. If it's feasible, have a nurse talk to the patient after the visit with the provider to ensure the care plan is understood and the patient feels their questions have been answered.

Are we able to find ways to incorporate the caregiver in the appointment? It is critical that the patient feel that the provider is talking to them, not their caregiver or someone else in the room. But, involving a caregiver at the appointment can allow for a more robust assessment of how the patient is doing. Encouraging caregiver attendance at appointments can supplement the care plan,

and allows a second perspective on questions and responses from the provider. Additionally, the caregiver can provide early warning signs of problem onset.

End of Life Discussion

Are we taking the time to have the end of life planning discussion with our patients? It is critical to discuss with the patient their end of life preferences. These discussions should be initiated after a patient "event" such as a hospital discharge, change in living situation such as a move to a retirement home, or change in health diagnosis, such as a new dementia diagnosis. Critically, it is important for you to discuss using life-sustaining technologies such as resuscitation, dialysis, feeding tubes, and antibiotic therapies. There are ample resources online to share with your patient so that they can understand what the implications are of the modalities they choose. Additionally, there are video decision support tools to educate patients about end of life care and choices, such as that from Dr. Angelo Volande's website.

As part of "What Matters Most" to the patient, do we explain the meaning of the disease diagnosis and the purpose of treatment, especially for chronic conditions? Just because a disease can be screened for, or treated in, the elderly population, doesn't mean that it should be treated. Often, seniors will agree to a treatment plan because their provider recommended it, not because they feel strongly that the treatment is needed or wanted. Older adults come from an era where they were taught that questioning physicians and treatment plans is wrong. Consider whether your patient really needs that screening test. For example, discuss with your 85 year old patient if a mammogram is necessary, or a colonoscopy in a 90 year old who has never had a polyp.

More is not always better. Be sure to address possible outcomes with the patient, both positive and negative. Keep the patient and caregiver informed and involved. For more information, refer to the publication by the American Medical Board Foundation called Choosing Wisely. This is available at http://www.choosingwisely.org

It can be very difficult for providers to initiate this type of conversation with their patients. Younger, poorer, minority and less educated people tend not to engage in these conversations with their doctor. In fact, only about 12% of providers initiate this conversation at all In order to have

this type of conversation, it's best to avoid being rushed, have enough space for everyone to be seated, have distractions removed, such as cell phones. It is critical to listen carefully to the patient, to find out their wishes and desires, and ensure you get them in writing. As a side note, it is possible to bill Medicare part A insurance (and possibly other types of insurance) for these discussions, if that is a practice concern.

Medication/Pharmacy:

Studies have shown that older adult patients are at high risk for multiple comorbidities, which results in them taking many medications. Almost 50% of older adult patients are taking medically unnecessary medications. It is important to review the medications the patient takes on a regular basis to ensure that medications are not being duplicated or causing deleterious side effects. Additionally, as we take patient concerns into account, it is possible that they may not want or even need to be on certain medications.

During the intake phone call or the appointment reminder phone call, does our scheduler request that the patient bring in a comprehensive medication list?

This medication list helps to ensure that the patient and the practice have the most current list of medications. Alternatively, if our clinic has time and resources, we can request that the patient bring in a "brownbag" of all their medications. When the patient arrives at the clinic, an RN or a trained MA can assess the medications and update them in the computer. Ideally, we will have a patient portal where patients can access their medication list and update as necessary.

When the patient brings in all their medications, we can survey what the patient is currently taking. The patient may have been given medications from various specialists, and by seeing visually what the patient is taking, we can reduce the rate of over prescription and polypharmacy. When making the appointment with the patient, your scheduler can say "please bring in an updated list of all the medications, or if you're more comfortable, bring in all medications including pills, creams, sprays, over the counter medications, herbal supplements and vitamins".

It is important for the medication list to be up to date, because medications can interact with each other, cause unpleasant side effects like confusion or incontinence. When a patient sees multiple providers, they could end up being prescribed too many medications, or medications with interactions.

4 – Care Plan (including coordinated care management)

When talking to the patient on the phone, does our scheduler encourage bringing a spouse, caregiver or friend to the appointment?

Seniors (and many younger patients) sometimes forget their questions while at the appointment. Additionally, a family member can help alert the provider to issues with or concerns about the patient. The scheduler can ask the patient "Will you be bringing a friend or caregiver with you? We welcome interested family or friends." This way, we are encouraging the patient to think about bringing someone to the appointment with them.

Who do we have dedicated to be the interface person in our practice? This person is typically the face to the practice, who the patient knows and can go to ensure their questions are being answered. Often this person is a pharmacist, nurse, a social worker, or a specially trained MA.

During the visit, are we using correct terminology when talking to our patients? Seniors want to know about their diseases, and the plan of action. They should be able to understand what they have, and what the process is going forward. The best way to do this is to explain in medical terminology, and then in plain English, what the patient has. For example, "The EKG shows a mild infarct in the past. That means your heart test showed you had a heart attack some time in the past. I am/am not concerned about this, and based on our discussions about what matters most to you, here is the plan of action."

After the visit, are we giving the patient a detailed, easy to understand care plan? Memory is fallible, but a written care plan is easy to refer to at home when questions arise. Additionally, the care plan can be taken to visits with other providers and is an easy way to refer to medications, diagnoses, and plan of action. The care plan should ideally include any vital signs from the visit, current weight, physician notes, exercise recommended, a complete list of medications and when they should be taken, and diagnoses with a plan of action developed by the physician and patient

together. The patient should be encouraged to take this care plan to all health related visits, so that all providers are on same page with diagnoses, medications, and actions to be taken.

For help building a care plan, see here:
https://www22.anthem.com/providertoolkit/ss3_updatedcareplanplaybook_abc.pdf

Have we asked the patient for the right to distribute the care plan digitally to family members or caregivers? This way, we are incorporating family in the care process for the patient, even if the caregiver or family member wasn't able to join in the visit.

Are we distributing a detailed, easy to understand care plan to the patient after their visit? Memory is fallible, but a written care plan is easy to refer to at home when questions arise. This care plan can be shared by the patient with family members who were not able to attend the visit. The care plan is an easy way to refer to medications, diagnoses, and plan of action. The care plan should ideally include any vital signs from the visit, current weight, physician notes, exercise recommended, a complete list of medications and when they should be taken, and diagnoses with a plan of action developed by the physician and patient together. Patient should be encouraged to take this care plan to all health related visits, so that all providers are on same page with diagnoses, medications, and actions to be taken. Additionally, we can consider asking patient for the right to distribute the care plan digitally to family members or caregivers who would like to be better informed about patient care. It is crucial to note that the careplan should be in plain language without complex medical qualifiers.

Are we making a follow-up call to the patient within 5 to 7 days after the appointment? A follow-up call can ensure that the patient understands the care plan, has been able to take medications as prescribed, and has been able to successfully make follow-up appointments as needed. Ideally, the practice will have a nurse, or specially trained MA call following an appointment to assess how patient has progressed after the visit and provide advice as necessary. This call will help ensure the patient has filled out prescription and understands how to take medications. Additionally, the phone call can assure that the patient understands the plan for future care.

In addition to the follow-up call within a week of the appointment, do we have a plan for

making a 2-3 month follow up call, especially for patients with new diagnoses or medications? This call can ensure that continuity of care remains during the time span between appointments. Additionally, problems can be identified early and remediated instead of being missed and possibly result in harm to the patient. These are the kinds of calls that can head off an expensive hospitalization – if we can spot the small problem before it becomes a huge one, we are honoring the patient's preferences. A nurse or other practitioner familiar with the patient can call, timeframe is dependent on acuity of illness, to follow up on a diagnosis, ensure treatment protocol is understood, or troubleshoot problems.

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