University of Southern Indiana Geriatrics Workforce Enhancement Program in partnership with the Deaconess Health System

Evansville, Indiana

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

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

About Us

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

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

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

The University of Southern Indiana Geriatrics Workforce Enhancement Program's (USI-GWEP) health system partner is the Deaconess Clinic, which is the multi-specialty medical group component of the Deaconess Health System, located in Evansville, Indiana. The primary care team at the Deaconess Clinic's downtown location consists of six internal medicine/family medicine physicians and one nurse practitioner. Approximately 30 additional employees are care team members, including a full-time, embedded Area Agency on Aging case manager and an advance care planning facilitator. The primary care team provides care for approximately 8,500 patients annually, 3,439 of whom are 65 years old and older (approximately 41% of the team's patient population).

What We Are Doing

This discussion exclusively focuses on the What Matters component of the 4M structure through a multimodal advance care planning (ACP) initiative within a primary care clinic. The ACP process supports older adults in understanding and sharing their personal values, life goals, and preferences regarding future medical care (Sudore, 2017). This Delphi definition of ACP mirrors our initiative's shift from exclusively focusing on the completion of an advance directive to engaging and supporting patients in reflection, discussion, and decision-making and, subsequently, toward addressing any part of the ACP process, including the completion of advance directives.

The ACP initiative was implemented within the Deaconess Clinic through the Medicare Annual Wellness Visit (AWV) for patients 65 years old and older. This AWV has no out-of-pocket costs to patients, and it includes optional assessment questions concerning ACP. Both these factors make ACP an attractive avenue to improve patient care. In addition, our ACP initiative was attentive to creating a multimodal experience to engage patients in a series of "ACP touches" before and during the AWV. It also incorporated use of a patient-facing, web-based platform, PREPARE TM for Your Care, to support the ACP process.

PREPARETM For Your Care (https://preparefory-ourcare.org) is a person-directed, evidence-based, multilingual (English/Spanish), interactive online ACP platform that supports individuals with limited health literacy in ACP decision-making and in completing an advance directive. The five steps of PREPARE are structured within the behavior change stage model—pre-contemplation

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

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to maintenance—(Prochaska, 1997) to allow participants to engage in the program based on their level of ACP readiness (Howard, 2016). Using short, interactive video scenarios, PREPARE assists individuals through five steps, including deciding what matters most in life, choosing a health care representative(s), and sharing the decisions with others (including health-related questions to ask medical professionals). This last prompt assists patients in viewing their ACP experience as a shared decision-making experience with their medical team. The USI-GWEP team has partnered with PREPARE to customize the PREPARE program access points for the primary care clinic and to track aggregate utilization data including number of accounts created and the number of individuals completing each of the PREPARE steps.

The ACP initiative was a new implementation for the clinic and is a collaborative effort involving many USI-GWEP partners. One physician piloted the ACP initiative with his AWV patients, and processes were reviewed and improved through a rapid continuous quality improvement process. All six other providers joined the initiative by the end of 2020.

Deaconess Clinic Primary Care Team and GWEP Team ACP Rapid Cycle Improvement Meeting (March 2020)

The ACP Initiative comprises six sequential steps that create a series of patient ACP touchpoints concerning "what matters" most. Some steps are automated, while others involve interaction with individual care team members. This combination allows patients at different levels of ACP readiness to engage in the model that makes most sense. The six steps consist of:

1. An AWV that addresses ACP
2. A letter and MyChart invitation by the physician to participate in the ACP initiative (sent 4-6 weeks before the AWV)
3. A phone call from the GWEP case manager to answer questions about the ACP initiative and PREPARE
4. A reminder that regardless of participation in the ACP initiative, ACP will be addressed during the AWV
5. An automated telephone or MyChart reminder of the ACP initiative five days before the AWV
6. Addressing ACP during the AWV followed by an immediate engagement by the ACP facilitator

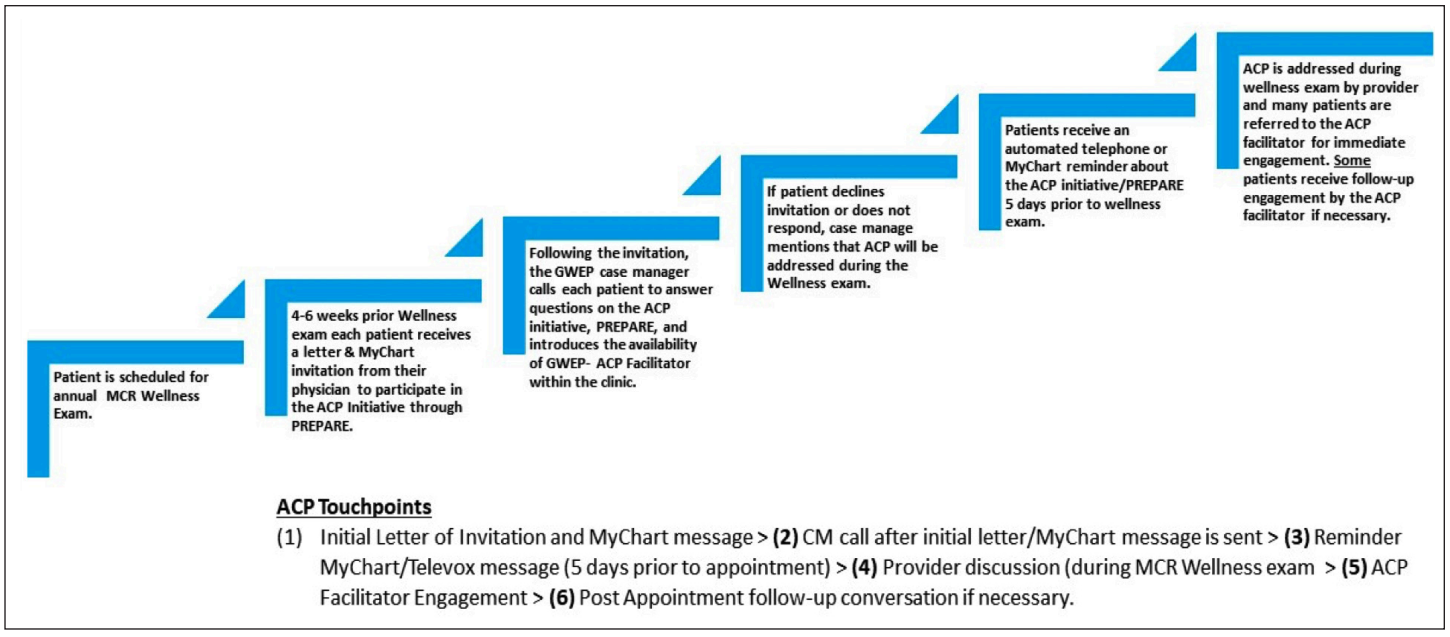

Figure 1. Steps/touchpoints involved in the USI-GWEP ACP initiative

Outcomes

The following eight monthly indicators are tracked and reported through a dedicated dashboard:

1. the number of PREPARE letters of invitation sent
2. the number of phone interactions with the Area Agency on Aging case manager
3. the number of PREPARE website accounts created and the cumulative number of PREPARE website visits
4. the cumulative number of patients asked about a medical decision-maker or the status of an advance directive during the AWV
5. the number of patients with advance directives on file at the time of the AWV
6. the cumulative number of advance directives filed since the start of the initiative (defined as new advance directives)
7. the advance directive score for patients 50 and older
8. the advance directive MIPS Score for patients 65 and older

The advance directive score for patients 50 and older and the advance directive MIPS score for patients 65 and older represent the percentage of patients whose medical record includes documentation of either

- an advance directive or a surrogate decision-maker, or
- that ACP was discussed and the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan

Three of the eight indicators listed above speak to the impact of the ACP initiative on patients: the number of PREPARE website accounts created, new advance directives, and advance directives on file.

Number of PREPARE website accounts created: The deliberate creation of PREPARE website accounts speaks to an increased readiness of the patients to engage in ACP. More than half of the unique website visits resulted in the creation of a PREPARE account (Figure 2).

Number of PREPARE Website Visits	
DCDT =	303
Number of PREPARE Website Accounts	
DCDT =	162

Figure 2. PREPARE website visits and new accounts (July 2020-June 2021)

New advance directives: 516 new advance directives were filed in the fiscal year. (Figure 3)

Advance directives on file at clinic visit: Note the percentage increase of patients that have an advance directive on file over the last fiscal (dark blue). (Figure 4)

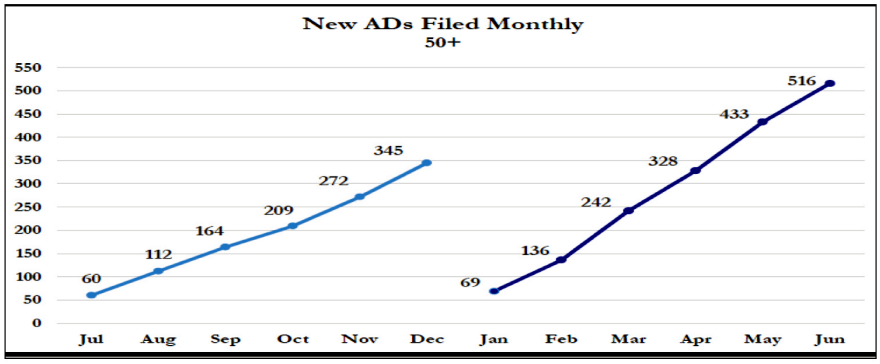

Figure 3. New advance directives filed monthly (cumulative) for patients 50 and older

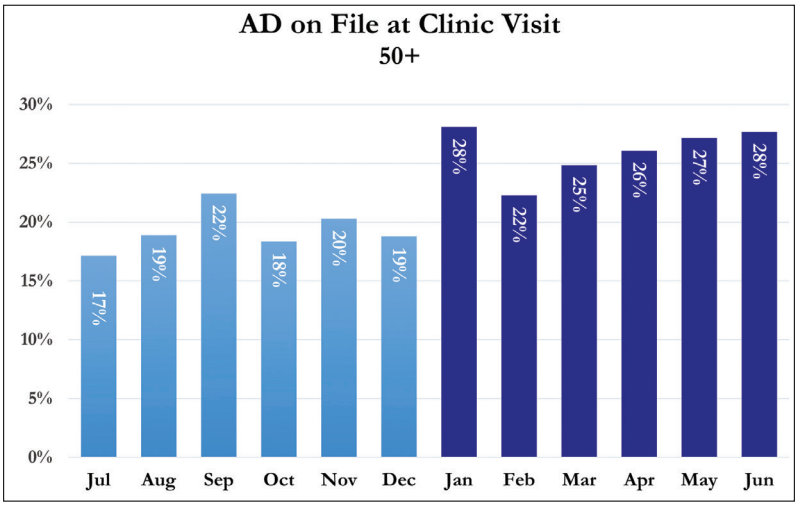

Figure 4. Advance directives on file at clinic visit for patients 50 and older

Case Study

In March 2021, 91-year-old man was scheduled for an AWV and participated in the ACP initiative. He returned to the clinic one month after the AWV with a completed Indiana PREPARE advance directive and consulted our ACP facilitator with questions and asked her to serve as a signatory witness. He indicated that he greatly valued the opportunity to participate in the ACP initiative because his wife of 60 years had passed away within the last year. She had died peacefully, but she had never engaged in any form of ACP, despite having cancer (twice!). He did not want to burden his family with decisions regarding his future medical care, designated his son as his healthcare representative, and provided copies of his advance directive to his entire family, including his grandchildren.

How We Spread What Matters Most

Most recently, the primary care department decided that each AWV should include dedicated time with the ACP facilitator. Although this presented some scheduling challenges, many more patients now have face time with the ACP facilitator, usually after their AWV with the provider.

The ACP initiative with a focus on the deliberative impact of the ACP facilitator is being considered for other Deaconess outpatient locations. In addition, the ACP facilitator's ability to bill Medicare (CPT 99497, 99498) presents an opportunity for the health system, especially because the patient has no out-of-pocket responsibility for ACP conversations that occur during the AWV.

Lessons Learned

The ACP initiative launched at the Deaconess downtown clinic's primary care department is evolving into a permanent fixture of the practice culture. Numerous lessons have been learned since inception, including the following:

- Piloting the ACP initiative with one physician first was an important step that allowed for analysis and revision of the ACP touchpoints before launching the initiative with the rest of the department.
- Determining the most impactful indicators is an evolving process that was not always quick and required assistance from multiple parties (including the Deaconess IT team). Sharing the indicators with the department has been motivational, as the physicians recognized ACP as providing good quality care for patients.
- Embedding the ACP facilitator and the case manager within the department makes the ACP initiative a team effort. These individuals play a role, as do the medical office assistants, clinical office assistants, and providers.

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