Practice Change Leaders (PCL) for Aging and Health

Project Summary

We will create an interdisciplinary geriatric team in an academic primary care practice at Mount Auburn Hospital. The Primary Care Center (PCC) at Mount Auburn Hospital (MAH) cares for over 500 older adults in the internal medicine primary care practice, and is a Level 3 accredited NCQA PCMH. Mount Auburn Hospital is a full-service academic community-teaching hospital affiliated with Harvard Medical School, serving a diverse patient population in the Cambridge metropolitan area.

The goals of the project are to 1.) optimize the medication regimens for older adults, and 2) reduce hospital readmissions. We will open a geriatric consultation clinic, one half-day session per week, coordinated by a geriatrician in the PCC. A new collaboration of team members already working in the practice will bring together the services of geriatrics, pharmacy, social work, home care and case management.

We will develop a Medication Optimization Program that reduces inappropriate medications and improves adherence. We also will create a Transitions Program that assists in the transition to home after discharge from a facility in order to prevent readmission.

Medication Optimization Program: We will proactively identify and invite older patients for consultation by the geriatrician and pharmacy staff if they are taking more than 8 medications, and/or are prescribed potentially inappropriate medications (e.g. Beer's List). The pharmacist and her trainees, along with the geriatrician, will evaluate and meet with patients and/or family to develop and document the appropriate care plans that address the use of inappropriate medications and barriers to adherence. The social worker and/or case manager will also be part of the team, available to assist in assessing the home environment, implementing suggestions of the team, and also making arrangements for home services if indicated.

Transitions Program: Confusion about medications at the time of transition is a major source of error in the care of older adults, leading to adverse events and readmissions. To address this, older adults recently discharged to home from the hospital or nursing facility will be contacted over the phone by the pharmacy team to reconcile medication lists, to clarify and review discharge medication lists, and to ensure patient and family understanding. Patients with a previous history of 30-day readmissions will be invited for consultation with the geriatric team. The MACIPA case manager and hospital social worker who conduct high-risk rounds will also help refer patients for evaluation, and the team will work closely with the homecare department and the case manager who will be available for home visits.

Process outcomes will include tracking of demographic information, reason for referral, and number of patients evaluated. Success will be demonstrated by 1.) 50% of identified high risk patients will be evaluated in the programs in the first year, 2.) 65% of evaluated patients will have a modification in their medications (e.g. reduction in total number of medications, reduction of high-risk medications, or evidence of improved adherence), and 3.) 25% reduction in hospital readmission rates in older adults in the PCC.