Nebraska Hospital Association

Age-Friendly Facilitator Guidebook

NHA | NEBRASKA HOSPITALS

Age-Friendly Health Systems

Institute for Healthcare Improvement

Introduction

Age-Friendly Health Systems is 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), designed to meet the healthcare needs of our nation's aging population.

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).

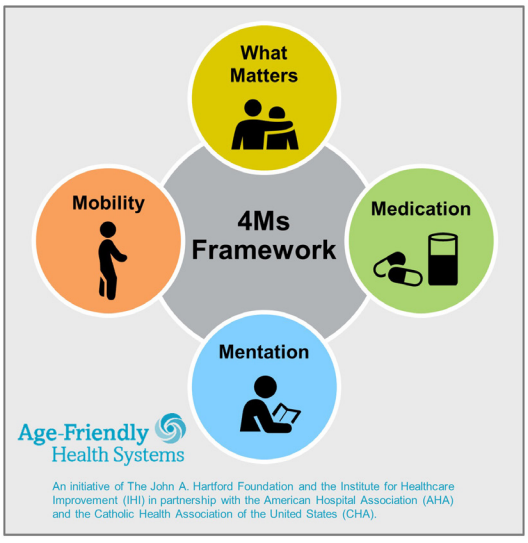
Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices
- Cause no harm
- Align with What Matters to the older adult and their family caregivers.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," to all older adults in your system:

- What Matters
- Medication
- Mentation
- Mobility

(Institute for Healthcare Improvement, 2023)



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

Background

Nebraska is a rural state with mostly Critical Access Hospitals (CAHs). Nebraska CAHs are vital resources for rural communities to have access to healthcare by keeping essential services in their own communities. Many healthcare providers within a CAH have a wide variety of skills to care for their patients.

The population of the United States is rapidly aging and by 2030, one of every five people in the U.S. will be 65 or older. By 2035, the number of adults older than 65 will be greater than the number of children under 18. This evidence-based project supports a well-designed program to improve outcomes and quality of life for our aging Nebraska residents. The Nebraska Hospital Association (NHA) has supported the Age-Friendly Movement since 2019 by assisting hospitals to adopt, implement, and sustain the 4Ms framework across the care continuum. As our patients continue to age, it is essential to spread this work to not only hospitals, but ambulatory care settings, post-acute care settings, communities, and so much more.

The Nebraska Hospital Association is committed to support and spread the Age-Friendly Movement throughout our state.

About this Guide

The Nebraska Hospital Association has a goal to spread the Age-Friendly Movement across our state, serving as a facilitator of the Age-Friendly program. Our team has put together a guide to assist other hospital associations with the implementation of this meaningful work.

This toolkit is an outline of the framework used to recruit, onboard, implement and sustain the Age-Friendly Program by the Nebraska Hospital Association. This guide is for organizations and specifically state-based hospital associations in the recruitment for and support of health systems becoming Age-Friendly.

The following document is a guide, not a specific set of rules. For specific questions related to the process, please use the included references.

Pre-Cohort:
Recruitment

Knowledge Share: Offer statewide program information to all member hospitals.

Key Elements:
- Ensuring a key contact is identified and designated.
- Give an overview that leaves leaders interested in learning more.

Drilldown Recruitment: Note any organizations that expressed interest and high-performing hospitals that are often early adopters.

Key Elements:
- Create a list of potential hospitals to begin individualized outreach.
- Start communication through calls, in-person, or web-based meetings with potential cohort members.

Gain Commitment: after individualized outreach, understand organization key contacts, and begin to ask for commitment.

Key Elements:
- Create a Letter of Intent: outlining expectations of each party.
- Meet with a member of the C-Suite to gain organizational wide commitment.
- Identify 1-2 people to serve as contacts throughout the program.

Other Recruitment Tactics

Use other association platforms to help establish relationships with potential facilities: conferences, newsletters, social media campaigns.

Provide Age-Friendly informational presentations at NHA sponsored conferences and other educational opportunities to increase the knowledge and accessibility of Age-Friendly education to facilities.

An important factor is building relationships and leveraging existing relationships to foster recruitment through 1:1 meetings with teams over zoom or in-person, where possible

Key Tools

- Age-Friendly Health Systems Action Community Education pamphlet: ensure you have this document for the specific cohort you are recruiting (see attachment A).
- IHI website www.ihi.org/agefriendly
- The Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices (see attachment B)
- The NHA website has links to several assessments and education backed by the Age Friendly Program: https://www.nebraskahospitals.org/quality_and_safety/age-friendly/
- Build a state focused curriculum to include discussion points during the statewide team webinars.

  Examples:
  - To facilitate Age-Friendly in the rural hospital, Nebraska facilitated state specific calls after each monthly national call. During these calls, participating hospitals benchmarked how they could develop action items specific to the small rural setting. With limited staff, NE hospitals shared resources amongst each other. For example, one small hospital had a geriatric certified pharmacist on staff. This pharmacist advised the whole group during the monthly calls.
  - The NHA also developed a state specific curriculum (see attachment C) using resources from IHI, AHA, and hospital systems who had presented on previous AF cohorts. A state specific curriculum was important because it placed all the "need-to-know" information in one location. Small hospitals, where team members wear many hats and often are not afforded the time to do research. NHA aimed to provide all needed rural relevant tools and resources in one location, along with clear goals for each month. This curriculum became the quick access tool for our rural hospitals.

Prepare for cohort

Schedule and create meeting requests for statewide team webinars, create agendas, review state-based curriculum to assure it follows national curriculum, create roster with contact information for committed participants. (Examples in attachment A)

- Calls with Quality and Team Leaders
- Monthly Webinars
- Monthly State Calls
- Coaching Calls

Onboarding

Ensure that the Letter of Intent is signed and submitted to IHI (Institute for Healthcare Improvement). (See Attachment D)

Work with key contacts to set up an onsite meeting with the participating organizations.

- Encourage the identified multidisciplinary team to attend including C-suite champion.
- Supply Education on the Age-Friendly journey and upcoming steps and requirements.
    - Define the specific department or group of patients that the program will be implemented. i.e., clinic, skilled nursing, rehab, orthopedic.
- Assign a champion for each of the four M's.
- Review timetable and responsibilities.
- Identify current processes, potential areas of strength and opportunity. (see Appendix A)
- Assist with Setting Goals and developing an AIM Statement. (see Appendix B)
- Aid with working on processes and requirements for Level 1.
- Assist with signing up facility to the IHI website and registration of meetings.
- Use the standardized work on the IHI external SharePoint Site

PARTICIPATE IN MONTHLY INTERACTIVE WEBINARS
Monthly content calls focused on 4Ms, an opportunity to share progress and learning with other teams

NHA AGE-FRIENDLY COACHING AND SUPPORT OF COMMUNITY SPREAD
On-site Consultation/Education

TEST AGE-FRIENDLY INTERVENTIONS
Test specific changes in your practice using the guide to using the 4Ms in the Care of Older Adults

SHARE DESCRIPTIONS OF 4MS CARE
Submit monthly qualitative feedback on your progress and description of 4Ms care

JOIN MONTHLY PEER-TO-PEER TOPICAL LEARNING CALLS
Join other teams for measurements and testing support in monthly drop-in coaching sessions on various subjects

LEADERSHIP TRACT TO SUPPORT SYSTEM-LEVEL SCALE UP
Leaders join monthly C-suite/Board level calls to set-up local conditions for scale up (hosted by IHI)

Cohort Begins

Progress to Level 1

To achieve level 1 – each facility must complete a 4Ms Care Description Worksheet for their care setting and submit to IHI for approval. Once the organizational plan is approved – Congratulations – Level 1: Age Friendly Health System Participant Certification has been received.

Facilitate submission of Level 1 information (4M's Care Description Worksheet) to IHI.

- Description worksheets are specific to areas, please use the IHI site: https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Recognition.aspx

Partner with IHI to support Level 1 submissions regarding all Level 1 submissions.

- Maintain open communication with IHI and the facility to facilitate swift and accurate completion of all requirements. The IHI team will send direct feedback to key contact regarding any adjustments needed to achieve Level 1 recognition.
- Set up regularly occurring touch base calls with IHI leads.
- Address any feedback from IHI team on Care Descriptions.

Once the organizational plan is approved – Congratulations – Level 1: Age Friendly Health System Participant Certification has been received.

Now It's Time To Go To Work

Assist with implementation, education, and assistance in process changes.

Review approved 4Ms Care Description and create an implementation plan for each section.

- Staff Education
- Documentation
- Patient and Family Engagement

Create a plan for data collection/reporting process.

Be open and available to address barriers and celebrate successes with all participants.

Set Up and Begin

Regularly schedule calls with Age-Friendly Lead and Team

Assure participants are registered for monthly team webinars that include the national and statewide calls.

Facilitate monthly state calls to follow IHI national call – during this time participants are asked to share their experiences, barriers, and questions encouraging peer learning.

Provide coaching calls and site visits as needed.

- Celebrate Completing level 1
- Use IHI's press release
- Engage the community

Achieve Level 1
Progress to Level 2

Level 2 is achieved following the full implementation of the approved 4Ms Care Description – and submission of 3-months of data counting the number of older adults who received the 4M's care.

Communicate with organizations regarding their implementation journey – assist with any needs to get the program efficiently embedded in the frontline staff's daily work.

Once the 4M's Care Model is fully implemented, create a data collection plan.

- Create EHR reports
- Develop audit tools
- Delegate audits to team members

Address any potential issues within process recognized through data collection to ensure effective implementation.

Once 3 months of data is collected, assist with the submission for Level 2 Recognition.

- Data collection documents are found at the end of the description worksheet: https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Recognition.aspx

Keeping the Momentum Going

Completed Level 2

Next Steps after Gaining Level 2 Certification:

Celebrate Completing level

- Use IHI's press release
- Engage the community

Create a work plan to spread facility wide.

Develop community outreach tools to engage other health care partners in the community to implement the Age-Friendly Framework.

Create statewide Age-Friendly Network.

- Regularly occurring educational opportunities
- List Serves
- Peer Learning

Develop and Maintain Annual Age Friendly Symposium.

- Use this platform to recognize newly certified organizations and encourage sustainability and spread for past participants.

Create an Age-Friendly Statewide Advisory Board.

- Ensure that membership mirrors your partnering Age-Friendly Organizations
- Allow this team to drive strategic initiatives for the state's Age-Friendly Movement.

Use Quality dashboards/scorecards to monitor quality improvement data involving the Age-Friendly program.

- Being prepared to re-engage facilities as needed.
- Use quality data and metrics to help re-engage facilities, new entities in the community, or new facilities.

Examples may include but are not limited to:

- Readmission reduction
- Improved patient satisfaction scores
- Decreased ED utilization
- Increased hospice and palliative care programs
- Reduced falls
- Delirium prevention, etc.

Create Return on Investment tools to further prove the effectiveness of the program.

Funding

- Utilize CMS Quality grants to support dedicated FTEs for implementation efforts.
- Explore local and national grant funding opportunities that may support full-time staff.
- Partnership with hospitals, communities, and other engaged organizations to allow for unique and innovative funding opportunities, i.e.i.e., Department of Health and Human Services, Nursing Home Associations, Public Health Departments, AARP, etc.

Tips

- Utilize IHI resources and websites.
- Reduce the burden on the facilities. Become partners in the project and help regularly.
- Understand and celebrate what facilities are doing well and build off their successes.
- Provide feedback via zoom, email, and in-person meetings to help establish relationships and foster teamwork between facilitator and facility. Use this time to give suggestions and provide support to the team.
- Check-in frequently with participants.
- Consider regular in-person meetings and/or check-ins.
- Start with small tests of change. Starting in a specific department allows the facility to fine-tune their processes and be successful. This will allow for effective implementation and an opportunity to spread across an organization and/or community.

FAQ

What is a typical implementation time frame?

For most facilities, an average time frame of 6 to 8 months can be expected, but each organization can vary dependent on size and available resources.

Who/What role is best to serve as the lead for a facility?

The leader of this project should be passionate about improving quality of care for elderly patients and have working knowledge on both the hands-on aspect of care and workflows to support the 4Ms framework. Ideal project managers They should be good communicators and change agents.

Who should be included on the facility implementation team?

Successful teams usually have a champion from all areas involved in the 4Ms framework in addition to a C-Suite leader to drive improvement.

What are the best ways to stay up to date with changes in the Age-Friendly Health Systems implementation process?

- Join the Friends of Age-Friendly Health Systems Community.
- Continue to commit and participate in the Age-Friendly Action Communities.
- Review best practices and resources regularly, i.e., IHI, AHA, NHA.

Impact

As the facilitator, you will be actively involved in several facilities and entities constantly. Having the ability to not only track and trend progress, but then transition to outcomes and measurable metrics is beneficial for both the facility and facilitator. Consider developing a plan for data entry and outcome metric review.

Data Entry

To decrease the burden of data entry to the Age-Friendly facilities, use already established data entry sources for benchmarking and tracking. Helpful sources such as state, CMS, or other data entry sites to prevent duplicate entry and will increase compliance.

Data Review

Consider quality metrics specific to the elderly patient and understand how to visualize progress and outcomes month over month. Harm metrics to consider may include fall rates, readmissions, adverse drug events, ED utilization, etc. Allowing for a clear understanding of progress made for patients, specifically 65+, will drive continued improvement and engagement from the team.

Impact at the State Level

Age-Friendly Hospitals in Nebraska have an average adverse drug reaction rate of less than 0.2% compared to the National Average of over 5% in 2022.

Nebraska Age-Friendly Facilities:

- Prevented over 750 excess patient days
- Saved hospitals over $750,0000
- Prevented over 546 ADE's

Age-Friendly Hospitals in Nebraska have consistently dropped readmission rates over 4.6% since 2020. This reduction in for Age-Friendly facilities in 2022 has resulted in:

- Preventing over 75 readmissions
- Saving facilities over $1.2 million

Resources

Institute for Healthcare Improvement. (2023). What is an age-friendly health system? Institute for Healthcare Improvement. Retrieved 2023, from https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Institute for Healthcare Improvement. (2023). Resources. Institute for Healthcare Improvement. Retrieved 2023, from https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Resources.aspx

Institute for Healthcare Improvement. (2023). Recognition. Institute for Healthcare Improvement. Retrieved 2023, from https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Recognition.aspx

Attachment

Attachment A (see page 8 of Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices)

Appendix A

Institute *for* Healthcare Improvement

Spring 2023 Age-Friendly Health Systems Action Community: **An Invitation to Join Us**

This content was created especially for:

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).

What Is an Age-Friendly Health System?

Three factors that impact the care of older adults in the United States today are occurring simultaneously, and together the factors make a compelling case for health systems to better support the needs of older adults and caregivers:

- *Demography*: The number of adults over the age of 65 is projected to double over the next 25 years.[1]
- *Complexity*: Approximately 80 percent of older adults have at least one chronic disease, and 77 percent have at least two.[2] Many of our health systems are ill-equipped to deal with the social complexity many older adults face.[3]
- *Disproportionate Harm*: Older adults have higher rates of health care utilization as compared to other age groups and experience higher rates of health care-related harm, delay, and discoordination. One consequence of this is a rate of ED utilization that is four times that of younger populations.[4]

Health systems frequently are not prepared for this complexity, and older adults suffer a disproportionate amount of harm while in the care of the health system. To address these challenges, in 2017, 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), set a bold vision to build a social movement so that all care with older adults is age-friendly care, which:

- Follows an essential set of evidence-based practices (knows as the 4Ms);
- Causes no harm; and
- Aligns with What Matters to the older adult and their family caregivers.

The 4Ms — What Matters, Medication, Mentation, and Mobility — make care of older adults that can be complex, more manageable. The 4Ms identify the core issues that should drive all care and decision making with the care of older adults. They organize care and focus on the older adult's wellness and strengths rather than solely on disease. The 4Ms are relevant regardless of an older adult's individual disease(s). They apply regardless of the number of functional problems an older adult may have, or that person's cultural, ethnic, or religious background.[1] The 4Ms are a framework, not a program, to guide all care of older adults wherever and whenever they touch your health system's care and services. The intention is to incorporate the 4Ms into existing care, rather than layering them on top, to organize the efficient delivery of effective care.

In 2020, the COVID-19 pandemic has put an increased burden on older adults, families, and staff in health systems. Perhaps especially during this challenging time, we have found that the 4Ms can reduce burden on care teams by providing an organizing framework to focus on the most critical care for older adults.

Age-Friendly Health Systems practice the 4Ms in every interaction with older adults. IHI recognizes care locations, such as hospitals, practices, retail-clinics, and nursing homes as Age-Friendly when they share a description of how they assess, document, and act on each of the 4Ms.

What Is an Age-Friendly Health Systems Action Community and How Can We Join?

An Action Community is a seven-month virtual learning opportunity to accelerate the adoption of the 4Ms with a network of teams from across different health systems. Guided by expert faculty and an "all teach all learn model," teams participate on monthly webinars, attend a convening, and test specific changes to improve care for older adults. The Action Community is designed as an on-ramp for hospital-based teams (e.g., emergency departments, intensive care units, general wards, medical-surgical units), ambulatory care teams (e.g., primary care, specialty care), nursing home teams (e.g., post-acute and long-term care) and convenient care clinic teams to test and adopt age-friendly care.

If you are **ready to enroll** in the 2023 IHI Action Community, please complete the registration form **using this link**.
Before accessing the registration form, you will be asked to log in or create an IHI account.

Learn More About the Action Community! Please join us in one of these informational calls for a high-level overview of the Age-Friendly Health Systems movement and engaging in the Action Community.	
Action Community Informational Call (The recording will be shared on this document after the call.) February 10th, 2023 from 11AM - 12PM (ET)	**Click Here to Join Zoom Meeting** **Password:** Friends23! If you are joining by phone: +1 305 224 1968 US Meeting ID: 893 7541 9235 Passcode: 9745278991
Action Community Informational Call (Most of this call will be dedicated to Q&A.) March 1st, 2023 from 11AM - 12PM (ET)	**Click Here to Join Zoom Meeting** **Password:** IHIafhs23! If you are joining by phone: +1 305 224 1968 US Meeting ID: 827 8286 4500 Passcode: 3233041661

What Happens During an Action Community?

Monthly Team Webinars	– Team Webinars are 60-minute webinars focused on understanding the steps for testing and implementing Age-Friendly care in your setting and illustrating 4Ms care in action. – ***Purpose***: Teams learn to describe how the 4Ms will be adapted and implemented in their setting and work towards reliable delivery to all older adults.
Peer Coaching Webinars	– Topical Peer Coaching Webinars provide an opportunity for participants to learn from one another and share ideas, successes, and challenges related to a specific topic or setting (e.g., optimizing the EHR, developing measurement systems). – ***Purpose***: Through peer sharing, teams identify specific ideas they can test and ways to address challenges.

Virtual Convening	– Across two days, teams will come together to learn with and from one another. A special focus will be placed on preparing for sustainability and spread. – ***Purpose***: Teams will come together across the Action Community to share ideas, build relationships, and learn approaches to sustainability and spread.
Ongoing Testing of Age-Friendly Interventions	– Informed by the Monthly Team Webinars and the Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices/Guide to Care of Older Adults in Nursing Homes participants will test and begin to implement specific key actions in their setting.
Recognition as an Age-Friendly Health System	- Action Community participants work towards two levels of recognition as an Age-Friendly Health System. 1. Recognition as an **Age-Friendly Health System - Participant**: determine how you will practice the 4Ms in your clinical care setting and submit a 4Ms Care Description. You will receive feedback from IHI on whether the description meets the minimum definition of an Age-Friendly Health System. The 4Ms Care Description for your setting type is available on IHI's website. 2. Recognition as an **Age-Friendly Health System - Committed to Care Excellence**: Once your description is approved by IHI, count the number of older adults that receive 4Ms care in your setting according to your description. You will be recognized at this level after submitting three months of counts.

What Are the Benefits of Participating?

- **Improved care for older adults through the organization and delivery of evidence-based care.** At the end of the seven-month Action Community, participating organizations will have implemented specific changes of the Age-Friendly Health Systems 4Ms Framework in their unit, clinic, emergency department, or program.

- **Recognition by IHI and The John A. Hartford Foundation as Age-Friendly Health Systems**. By submitting a description of how you are operationalizing the 4Ms in your setting, as well as monthly counts of the older adults reached by 4Ms care in your setting, you will be recognized and celebrated on IHI's website, in press releases, and in other venues as being an Age-Friendly Health System, Committed to Care Excellence.

- **All teach all learn model.** By participating in the Action Community, you will have the opportunity to build relationships and learn from expert faculty, as well as peers around the country that have found innovative solutions to similar challenges and obstacles that you may face. In addition, you will have opportunities to share your organization's learning and celebrate its progress with the movement.

What Is the Cost to Participate?

There is no fee to participate in the Age-Friendly Health Systems Action Community. A health system, hospital, or practice in the US can enroll as many sites/teams as it would like to participate in testing the 4Ms. Many organizations that have participated in previous Action Communities will join and focus on spreading the 4Ms to additional care locations in their health system.

The cost of participation includes the time your team will allocate to engage in Action Community activities such as participating on monthly webinars, attending the virtual meeting, testing specific changes in their daily work, and asking questions and sharing progress in between program activities. To be recognized as an Age-Friendly Health System, your hospital and practice must submit a brief description of how they are operationalizing the 4Ms.

The Age-Friendly Health Systems 4Ms is a framework for the delivery of improved, evidence-based care and it is not a program or model to be layered on top of existing care. Given that, the 4Ms guides how existing resources are used and does not necessarily require new resources. IHI developed The Business Case for Becoming an Age-Friendly Health System to help organizations understand the potential financial benefits of becoming an Age-Friendly Health System.

What Data Submission Is Required to Participate?

To participate in the Action Community and be recognized as an Age-Friendly Health System, you will share with IHI how you plan to put the 4Ms into practice. Completion of this initial step will result in you being recognized as an Age-Friendly Health System-Participant. The 4Ms Care Description for your setting type is available on IHI's website. Once your description of putting the 4Ms into practice is reviewed by IHI for alignment with an Age-Friendly Health System, you will be invited by IHI to share a count of older adults whose care includes the 4Ms each month, for three months. Completion of this step will result in you being recognized as an Age-Friendly Health System-Committed to Care Excellence.

During the Action Community, you will learn how to set up a measurement dashboard to study the impact of adopting the 4Ms in your setting. This is an important step in putting the 4Ms into practice and is critical for sustaining and spreading your age-friendly efforts. **However, your team will not be required to report this data to IHI.**

Partners

Age-Friendly Health Systems is 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).

The Action Community also draws on the expertise of the Advisory Group and experts in the 4Ms, testing and scale-up methodology, and organizational psychology. A full list of advisors can be found on www.ihi.org/AgeFriendly.

Questions?

If you are **ready to enroll** in the 2023 IHI Action Community, please complete the registration form **using this link**. Before accessing the registration form, you will be asked to log in or create an IHI account.

Please do not hesitate to contact the IHI Age-Friendly Health Systems team by emailing AFHS@IHI.org. We look forward working together to ensure that every older adult always receives age-friendly care.

References

[1] *The State of Aging and Health in America 2013*. Atlanta: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2013. https://www.cdc.gov/aging/pdf/State-Aging-Health-in-America-2013.pdf

[2] "Fact Sheet: Healthy Aging." National Council on Aging; 2016. https://www.ncoa.org/resources/fact-sheet-healthy-aging/

[3] Abrams M, Milstein A. NAM Workshop Series on High-Need Patients. National Academy of Medicine; October 2016. https://nam.edu/wp-content/uploads/2016/12/Taxonomy-and-care-model-presentation-FINAL.pdf

[4] Institute of Medicine Committee on the Future Health Care Workforce for Older Americans. *Retooling for an Aging America: Building the Health Care Workforce*. Washington, DC: National Academies Press; 2008. 2, Health Status and Health Care Service Utilization. https://www.ncbi.nlm.nih.gov/books/NBK215400/

Appendix B

Institute for Healthcare Improvement

Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices

July 2020

This content was created especially for:

Age-Friendly Health Systems

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This work was made possible by The John A. Hartford Foundation, a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. For more information, visit www.johnahartford.org.

IHI would like to thank our partners, the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), for their leadership and support of the Age-Friendly Health Systems initiative. Learn more at ihi.org/AgeFriendly.

Thank you to the five prototype health systems — Anne Arundel Medical System, Ascension, Kaiser Permanente, Providence St. Joseph, and Trinity — for stepping forward to learn what it takes to become an Age-Friendly Health System.

IHI is thankful to the Age-Friendly Health Systems Faculty and Advisory Groups (see Appendix A). We extend our deepest gratitude to co-chairs Ann Hendrich, PhD, RN, and Mary Tinetti, MD; and to Nicole Brandt, PharmD, MBA, Donna Fick, PhD, RN, and Terry Fulmer, PhD, RN. We are grateful to Cayla Saret and Val Weber of IHI for their support in editing this document. The authors assume full responsibility for any errors or misrepresentations. Thank you to the core team at IHI that has worked on the Age-Friendly Heath Systems initiative — Kedar Mate, Leslie Pelton, Karen Baldoza, and KellyAnne Johnson Pepin — and all advisors, faculty and staff.

Contents

Age-Friendly Health Systems Overview

The United States is aging. The number of older adults, individuals ages 65 years and older, is growing rapidly. As we age, care often becomes more complex. Health systems are frequently unprepared for this complexity, and older adults suffer a disproportionate amount of harm while in the care of the health system.

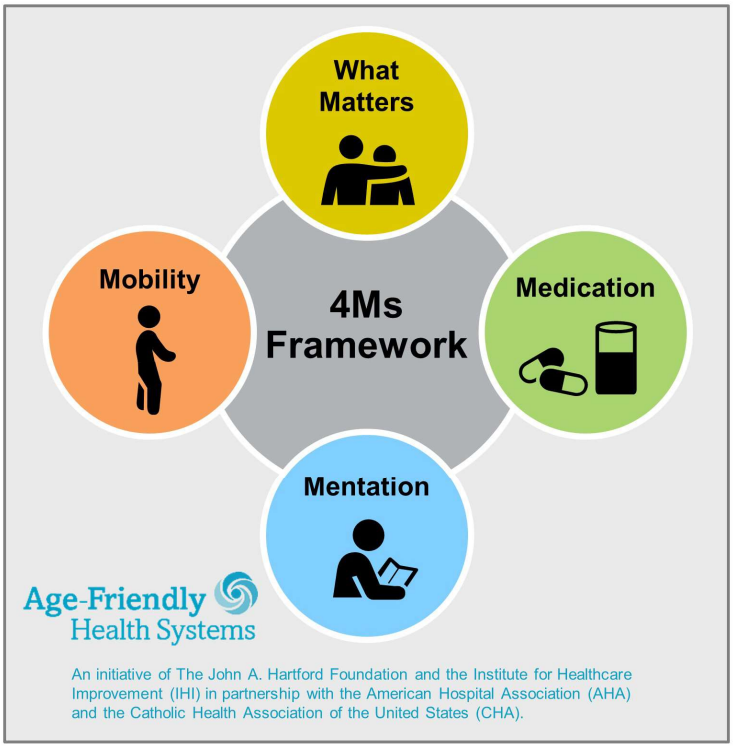
To address these challenges, in 2017, The John A. Hartford Foundation (JAHF) and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), set a bold vision to build a social movement so that all care with older adults is age-friendly care. According to our definition, age-friendly care:

- Follows an essential set of evidence-based practices;
- Causes no harm; and
- Aligns with What Matters to the older adult and their family or other caregivers.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," to all older adults in your system. When implemented together, the 4Ms represent a broad shift by health systems to focus on the needs of older adults (see Figure 1).

The Age-Friendly Health Systems movement now comprises several hundred hospitals, practices, and post-acute long-term care (PALTC) communities working to reliably deliver evidence-based care for older adults. IHI and JAHF celebrate the participation of organizations that have committed to practicing age-friendly 4Ms care. Learn more about how you can join the movement and show your commitment to better care for older adults at ihi.org/AgeFriendly.

Figure 1. 4Ms Framework of an Age-Friendly Health System



For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

The 4Ms — What Matters, Medication, Mentation, and Mobility — make care of older adults, which can be complex, more manageable. The 4Ms identify the core issues that should drive all decision making in the care of older adults. They organize care and focus on the older adult's wellness and strengths rather than solely on disease. The 4Ms are relevant regardless of an older adult's individual disease(s). They apply regardless of the number of functional problems an older adult may have, or that person's cultural, racial, ethnic, or religious background.[1]

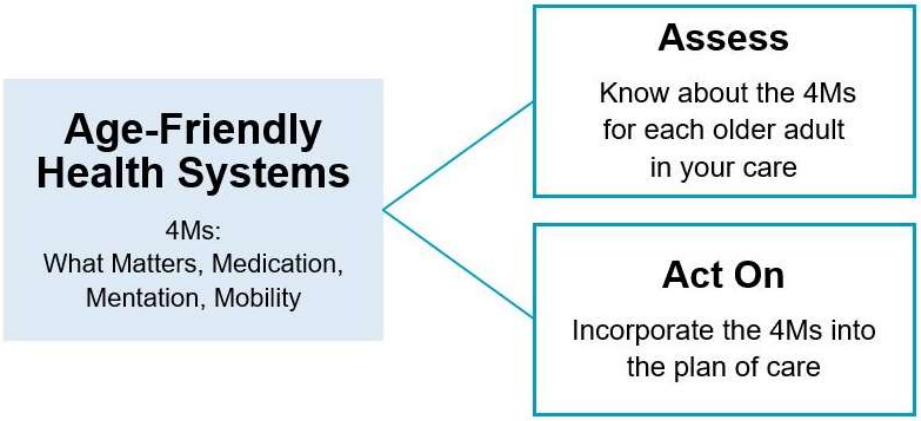
The 4Ms are a framework, not a program, to guide all care of older adults wherever and whenever they come into contact with your health system's care and services. The intention is to incorporate the 4Ms into existing care, rather than layering them on top, in order to organize the efficient delivery of effective care. This integration is achieved primarily through redeploying existing health system resources. Many health systems have found they already provide care aligned with one or more of the 4Ms for many of their older adult patients. Much of the effort, then, involves incorporating the other elements and organizing care so that all 4Ms guide every encounter with an older adult and their family or other caregivers.

4Ms Framework: Not a Program, But a Shift in Care

- The 4Ms Framework is not a program, but a shift in how we provide care to older adults.
- The 4Ms are implemented together (i.e., all 4Ms as a set of evidence-based elements of high-quality care for older adults).
- Your system probably practices at least a few of the 4Ms in some places, at some times. Engage existing champions for each of the 4Ms, build on what you already do, and spread it across your system.
- The 4Ms must be practiced reliably (i.e., for all older adults, in all settings and across settings, in every interaction).

There are two key drivers of age-friendly care: knowing about the 4Ms for each older adult in your care ("assess"), and incorporating the 4Ms into the plan of care accordingly ("act on") (see Figure 2). Both must be supported by documentation and communication across settings and disciplines.

Figure 2. Two Key Drivers of Age-Friendly Health Systems



Developed with our expert faculty and advisors (see Appendix A) and five pioneering health systems — Anne Arundel Medical Center, Ascension, Kaiser Permanente, Providence, and Trinity Health — this Guide to Using the 4Ms in the Care of Older Adults is designed to help care teams test and implement a specific set of evidence-based, geriatric best practices that correspond to each of the 4Ms. Though assessing and acting on the 4Ms is similar in most care settings, there are some differences. This Guide begins by outlining the 4Ms for hospital-based and ambulatory/primary care-based settings.

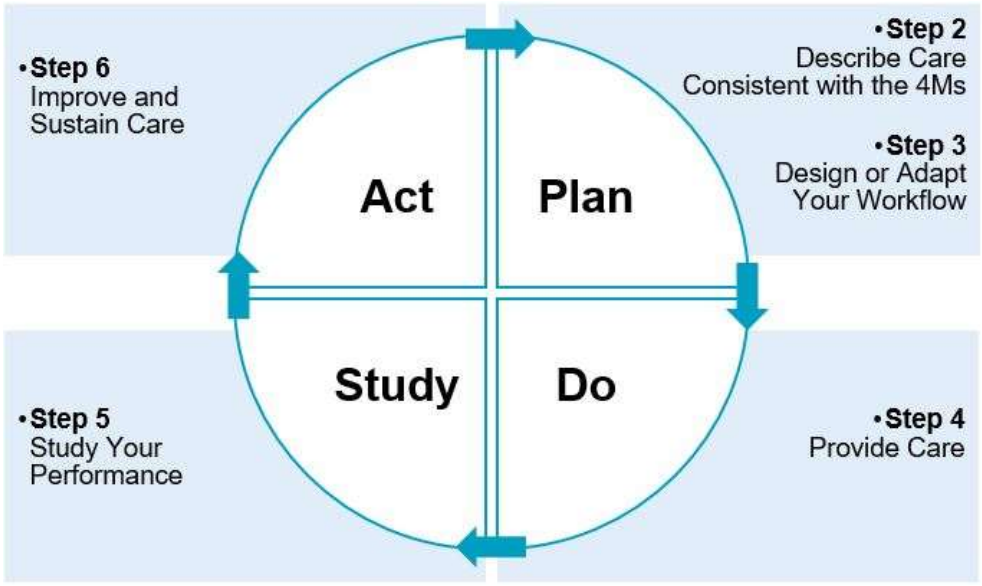
Putting the 4Ms into Practice

A "recipe" for integrating the 4Ms into your standard care has steps and ingredients, just like a recipe. These steps include:

1. Understand your current state
2. Describe care consistent with the 4Ms
3. Design or adapt your workflow
4. Provide care
5. Study your performance
6. Improve and sustain care

While we present the six steps as a sequence, in practice you can approach steps 2 through 6 as a loop aligned with Plan-Do-Study-Act cycles (see Figure 3).

Figure 3. Integrating the 4Ms into Care Using the PDSA Cycle



Step 1. Understand Your Current State

The aim of an Age-Friendly Health System is to reliably apply the two key drivers of age-friendly care: assess and act on the 4Ms with all older adults. Almost all systems integrate some of the 4Ms into care, some of the time, with some older adults, in some place in their system. With an understanding of your current experience and capacity to engage in 4Ms care, you can build on that good work until the 4Ms are reliably practiced with all older adults.

The following steps help you prepare for your journey to becoming an Age-Friendly Health System by understanding your current state – knowing the older adults and the status of the 4Ms in your health system currently — and then selecting a care setting and establishing a team to begin testing.

Know the Older Adults in Your Health System

Estimate the number of adult patients you served in each age group in the last month (see Table 1).

Table 1. Adult Patients Served in the Last Month (by Age Group)

Age Group	Number	Percent of Total Patients
18–64 years		
65–74 years		
75–84 years		
85+ years		
Total Number of Adult Patients		**100%**

For adult patients ages 65 and older in your care, specify their language, race/ethnicity, religious and cultural preferences (see Table 2), and health literacy levels (see Table 3).

Table 2. Language, Race/Ethnicity, and Religious and Cultural Preferences of Patients 65 Years and Older

Language:	Percent of Total Patients Ages 65+
Race/Ethnicity:	**Percent of Total Patients Ages 65+**
Religious and Cultural Preferences:	**Percent of Total Patients Ages 65+**

Table 3. Health Literacy Levels of Patients 65 Years and Older

Health Literacy Level	Percent of Total Patients Ages 65+
Low	
Moderate	
High	

Know the 4Ms in Your Health System

To identify where the 4Ms are in practice in your health system, walk through activities as if you were an older adult or family member or other caregiver. In an ambulatory setting, that may include making an appointment for an Annual Wellness Visit, preparing to come to an Annual Wellness Visit, observing an appointment, and understanding who on the care team takes responsibility for each of the 4Ms. In an inpatient setting, go through registration, spend time on a unit, and sit quietly in the hall of a unit. Look for the 4Ms in action. You will find aspects that make you proud and others that leave you disappointed. Try not to be judgmental. Find bright spots, opportunities, and champions of each of the 4Ms in your system.

Use the form provided in Appendix B to note what you learn.

Select a Care Setting to Begin Testing

Once you know about your older adults and identify where the 4Ms currently exist in your health system, select a care setting in which to begin testing age-friendly interventions. Some questions to consider when selecting a site:

- Is there a setting where a larger number of older adults regularly receives care?
- Is there will at this setting to become age-friendly and improve care for older adults? Is there a champion?
- Is this setting relatively stable (i.e., not undergoing major changes already)?
- Does this setting have access to data? (See the "Study Your Performance" section below for more on measurement. Data is useful, though not required.)
- Can this setting be a model for the rest of the organization? (Modeling is not necessary, but useful to scale-up efforts.)
- Is there a setting where your team members have experience with the 4Ms either individually or in combination? Do they already have some processes, tools, and/or resources to support the 4Ms?
- Is there a setting where the health literacy levels, language skills, and cultural preferences of your patients match the assets of the staff and the resources provided by your health system?

Set Up a Team

Based on our experience, teams that include certain roles and/or functions are most likely to succeed (see Table 4).

Table 4. Team Member Roles

Team Member	Description
An Older Adult and Caregiver	Patients and families or other caregivers bring critical expertise to any improvement team. They have a different experience with the system than providers and can identify key issues. We highly recommend that each team has at least one older adult, family member, or other caregiver (ideally more than one), or a way to elicit feedback directly from these individuals (e.g., through a Patient and Family Advisory Council). Additional information about appropriately engaging patients and families in improvement efforts can be found on the Valuing Lived Experience: Why Science Is Not Enough and Institute for Patient- and Family-Centered Care website.
Leader/Sponsor	This person champions, authorizes, and supports team activities, as well as engages senior leaders and other groups within the organization to remove barriers and support implementation and scale-up efforts. Although they may not do the "on-the-ground" work, the leader/sponsor is responsible for: • Building a case for change that is based on strategic priorities and the calculated return on investment; • Encouraging the improvement team to set goals at an appropriate level; • Providing the team with needed resources, including staff time and operating funds; • Ensuring that improvement capability and other technical resources, especially those related to information technology (IT) and electronic health records (EHR), are available to the team; and • Developing a plan to scale up successful changes from the improvement team to the rest of the organization.
Administrative Partner	This person represents the disciplines involved in the 4Ms and works effectively with the clinicians, other technical experts, and leaders within the organization. We recommend placing the manager of the unit where changes are being tested in this role because that individual can likely move nimbly to take necessary action and make the recommended changes in that unit and is invested in sustaining changes that result in improvement.
Clinicians who Represent the Disciplines Involved in the 4Ms	These individuals may include a physician, nurse, physical therapist, social worker, pharmacist, chaplain, and/or others who represent the 4Ms in your context. We strongly encourage interprofessional representation on your team and urge you to enlist more than one clinical champion. These champions should have good working relationships with colleagues and be interested in driving change to achieve an Age-Friendly Health System. Consider professionals who are opinion leaders in the organization, who are sought by others for advice, and who are not afraid to test and implement change.
Others	• Improvement coach • Data analyst/EHR analyst • Finance representative

Step 2. Describe Care Consistent with the 4Ms

There are many ways to improve care for older adults. However, there is a finite set of key actions, summarized below, that touch on all 4Ms and dramatically improve care when implemented together (see Table 5). This list of actions is considered the gateway to your journey to becoming an Age-Friendly Health System. In Appendix D you will find a list of these key actions and ways to get started with each one in your setting, as well as additional tips and resources. Be sure to plan how you will document and make visible the 4Ms across the care team and settings.

Using the 4Ms Care Description Worksheet provided in Appendix C, describe a plan for how your system will provide care consistent with the 4Ms. This worksheet helps you to assess, document, and act on the 4Ms as a set, while customizing the approach to practicing the 4Ms for your context. To be considered an Age-Friendly Health System, your system must engage or assess people ages 65 and older for all 4Ms, document 4Ms information, and act on the 4Ms accordingly. As you test the 4Ms, you may make updates to your Description based on what you learn about the tools and methods that work best in your context.

Questions to consider:

- How does your current state compare to the actions outlined in the 4Ms Care Description Worksheet?
- Which of the 4Ms do you already incorporate? How reliably are they practiced?
    - For example: Do you already ask and document What Matters, review for high-risk medication use, screen for delirium, dementia, and depression, and screen for mobility for each older adult?
- Where are there gaps in 4Ms? What ideas do you have to fill the gaps? Some ideas for how to get started filling those gaps are provided in Appendix D.

In this step, describe the initial plan for 4Ms care for the older adults you serve.

Set an Aim

Given your current state, set an aim for this initial effort. An aim articulates what you are trying to accomplish — what, how much, by when, for whom. It serves as the focus for your team's work and enables you to measure your progress. Below is an aim statement template that requires you to think about the reach of 4Ms. We suggest starting with what you want to accomplish in the next six months.

Aim Statement Template

By [DATE], [NAME OF ORGANIZATION] will articulate how it operationalizes 4Ms care and will have provided that 4Ms care in [NUMBER] of encounters with patients 65+ years old.

Step 3. Design or Adapt Your Workflow

Many ideas you may have in place already. You can maintain, improve, and expand them where necessary. Other ideas you may still need to test and implement. The key is to ensure that these practices are reliable — happening every time in every setting for every older adult you serve (and their caregives).

Table 5. Age-Friendly Health Systems Summary of Key Actions

	Assess	Act On
	Know about the 4Ms for each older adult in your care	Incorporate the 4Ms into the plan of care
Hospital	**Key Actions (to occur at least daily):**	
	• Ask the older adult What Matters • Document What Matters • Review for high-risk medication use • Screen for delirium at least every 12 hours • Screen for mobility limitations	• Align the care plan with What Matters • Deprescribe and dose-adjust high-risk medications and avoid their use whenever possible • Ensure sufficient oral hydration • Orient older adults to time, place, and situation • Ensure that older adults have their personal adaptive equipment • Prevent sleep interruptions; use nonpharmacological interventions to support sleep • Ensure early, frequent, and safe mobility
Ambulatory	**Key Actions (to occur at least annually or after change in condition):**	
	• Ask the older adult What Matters • Document What Matters • Review for high-risk medication use • Screen for cognitive impairment • Screen for depression • Screen for mobility limitations	• Align the care plan with What Matters • Deprescribe and dose-adjust high-risk medications, and avoid their use whenever possible • If cognitive impairment screen is positive, refer for further evaluation and manage manifestations of cognitive impairment • If depression screen is positive, identify and manage factors contributing to depression and initiate, or refer out, for treatment • Ensure safe mobility

Supporting Actions:

- Use the 4Ms to organize care and focus on the older adult, wellness, and strengths rather than solely on disease or lack of functionality.
- Integrate the 4Ms into care or existing workflows.
- Identify which activities you can stop doing to reallocate resources to reliably practice the 4Ms.
- Document all 4Ms and consider grouping the 4Ms together in the medical record.
- Make the 4Ms visible across the care team and settings.
- Form an interdisciplinary care team that reviews the 4Ms in daily huddles and/or rounds.
- Educate older adults, caregivers, and the community about the 4Ms.
- Link the 4Ms to community resources and supports to achieve improved health outcomes.

Overall, look for opportunities to combine or redesign activities, processes, and workflows around the 4Ms. In this effort you may find that you can stop certain activities and reallocate resources to support age-friendly care.

If you have process flow diagrams or value-stream maps of your daily care, edit these views of your workflow to include the key actions above and your description of age-friendly care.

You may start with a high-level workflow like the examples shown below (see Figures 4 and 5).

Figure 4. Age-Friendly Care Workflow Example for Hospitals: Core Functions

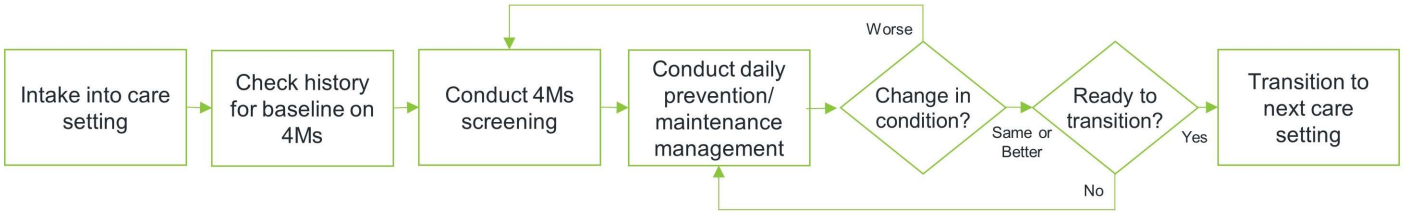
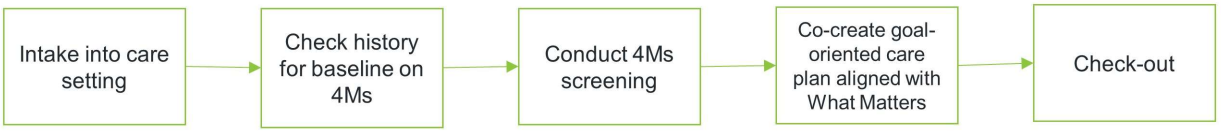


Figure 5. Age-Friendly Care Workflow Example for Primary Care: Core Functions for New Patient, Annual Visit, or Change in Health Status



Then work through the details in the space below each high-level block to show how you will incorporate the 4Ms. Be specific about who will do what, where, when, how, and how it will be documented. Examples are included in Appendix E.

Outline what you still need to learn and identify what you will test (e.g., using the Timed Up & Go Test to evaluate mobility and fall risk).

Step 4. Provide Care

Learn as you move toward reliable 4Ms care. Begin to test the key actions with one older adult and their family or other caregivers as soon as you have notes for step 2, Describe Care Consistent with the 4Ms, and step 3, Design or Adapt Your Workflow. Do not wait to have your forms or EHR screens finalized before you test with one older adult. Use the Plan-Do-Study-Act tool to learn more from your tests. Then, scale up your tests. For example:

- Apply your draft standard procedure and workflow first with one patient. Can your team follow the procedure in your work environment?
- If necessary, modify your procedure. Then, apply it with five patients. What lessons do you learn from applying 4Ms care with these patients? What impact does learning about all 4Ms have on care plans?
- If necessary, modify your procedure. Then, apply with 25 patients and keep going. Are you getting close to being able to use your procedure for every patient? Are you getting good results?
- Examples of PDSA cycles can be found in Appendix F.

Step 5. Study Your Performance

How reliable is your 4Ms care? What impact does your 4Ms care have? Here is an approach to study your performance.

Observe and Seek to Understand

Observe: Start your study with direct observation of your draft 4Ms Care Description in action.

- Can your team follow the Care Description and successfully assess and act on the 4Ms with the older adults in your care?
- Do your care plans reflect 4Ms care?

In the first month, do this for at least one patient each week. Then, for the next six months, observe 4Ms care for at least five patients each month.

Ask Your Team: At least once per month for the seven months of your efforts, ask your team two open-ended questions and reflect on the answers:

- What are we doing well to assess and act on the 4Ms?
- What do we need to change to translate the 4Ms into more effective care?

Plan with your team how and when you will continue to reflect together using open-ended questions on an ongoing basis.

Ask Older Adults and Caregivers: At least once in the first month of your effort, ask an older adult and family or other caregiver two open-ended questions and reflect on the answers:

- What went well in your care today?
- What could we do better to understand what age-friendly care means to you?

Then try the questions with five additional older adults in the second month. Plan with your team how and when you will continue to talk with older adults using open-ended questions on an ongoing basis. Consider engaging an older adult as a member of the team that is working to adopt the 4Ms.

Measure How Many Patients Receive 4Ms Care

There are three options to start measuring the number of patient encounters that include 4Ms care. We recommend Option 1 because it forces close attention to the 4Ms work and takes less effort than conducting retrospective chart audits or building a specific EHR report.

Option 1: Real-Time Observation

Use real-time observation and staff reporting of the work to tally your 4Ms counts on a whiteboard or paper. An example for patients seen in the primary care clinic might look like the chart below (see Figure 6).

Figure 6. Example of Real-Time Observation in a Primary Care Clinic

Date	*4Ms Care according to our site description*											
	All 4Ms		What Matters		Medications		Depression		Dementia		Mobility	
Pt ID	if N, check details											
101	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
102	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
103	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
104	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
105	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
106	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
107	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
108	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
109	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
110	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
111	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
112	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
113	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
114	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
115	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Option 2: Chart Review

Using a tally sheet like the example discussed in Option 1, review charts for evidence of 4Ms care. At the start of your work using the 4Ms, review charts of patients with whom you have tested 4Ms care (M) to confirm proper documentation. To estimate the number of patient encounters that include 4Ms care in a particular time period (e.g., monthly), randomly sample 20 charts from patients who received care during that time (out of M). Observe out of the 20 how many received your described care (C).

Calculate the approximate number of patient encounters that include 4Ms care in the time period as follows:

Estimated number of patient encounters including 4Ms care = (M x C) divided by 20

Option 3: EHR Report

You may be able to run EHR reports, especially on assessment of the 4Ms, to estimate the number of patient encounters that include 4Ms care in a particular time period. It may take a lot of effort to create a suitable report, so we do not recommend this option as your first choice. However, for ongoing process control, some organizations may wish to develop reports that show 4Ms performance; you can request report development from your IT service while starting with Option 1 or 2.

Routine Counting of Patients

Once your site provides 4Ms care with high reliability (see Appendix G), then the estimate of the number of patient encounters that include 4Ms care is simple: Report the volume of patients receiving care from your site during the measurement period.

Additional Measurement Guidance and Recommendations

The tables below provide additional guidance for counting the number of patients receiving age-friendly (4Ms) care.

Hospital Site of Care	
Measure Name	Number of Patients Who Receive Age-Friendly (4Ms) Care
Measure Description	Number of patients 65+ who receive 4Ms care as described by the hospital
Site	Hospital
Population Measured	Adult patients 65+
Measurement Period	Monthly
Count	Inclusion: Patients 65+ with LOS>=1 day present on the unit between 12:01 AM on the first day of the measurement period and 11:59 PM on the last day of the measurement period who receive the unit's description of 4Ms care

Measure Notes	• The measure may be applied to units within a system as well as the entire system. See the 4Ms Care Description Worksheet to describe 4Ms care for your unit. To be considered age-friendly (4Ms) care, you must engage or screen all patients 65+ for all 4Ms, document the results, and act on them as appropriate. • If a total count is not possible, you can sample (e.g., audit 20 patient charts) and estimate the total number of patient encounters using 4Ms care/20 x total number of patients cared for in the measurement period. If you are sampling, please note that when sharing data. • Once you have established 4Ms care as the standard of care on your unit, validated by regular observation and process review, you can estimate the number of patients receiving 4Ms care as the number of patients cared for by the unit. • You do not need to filter the number of patients by unique medical record number (MRN).

Ambulatory/Primary Care Site of Care	
Measure Name	Number of Patients Who Receive Age-Friendly (4Ms) Care
Measure Description	Number of patients 65+ who receive 4Ms care as described by the measuring unit
Site	Ambulatory
Population Measured	Adult patients 65+
Measurement Period	Monthly
Count	Inclusion: All patients 65+ in the population considered to be patients of the ambulatory or primary care practice (e.g., patient assigned to a care team panel and seen by the practice within the past three years) who have an office visit, home visit, or tele-medicine visit with the practice during the measurement period and who receive 4Ms care as described by the site. Exclusions: None
Measure Notes	• The measure may be applied to units within a system as well as the entire system. • See the 4Ms Care Description Worksheet to describe 4Ms care for your unit. To be considered age-friendly (4Ms) care, you must engage or screen all patients 65+ for all 4Ms, document the results, and act on them as appropriate. Note that the 4Ms screening in primary care may be defined as screening within the previous 12 months. • If a total count is not possible, you can sample (e.g., audit 20 patient charts) and estimate the total as the number of patients receiving 4Ms care/20 x total number of patients cared for in the measurement period. If you are sampling, please note that when sharing data. • Once you have established 4Ms care as the standard of care on your unit, validated by regular observation and process review, you can estimate the number of patients receiving 4Ms care as the number of patients cared for by the unit. • You do not need to filter the number of patients by unique MRN.

See Appendix H for additional recommendations on measuring the impact of 4Ms care.

Step 6. Improve and Sustain Care

For more information about how to sustain your 4Ms care, please see the IHI White Paper, *Sustaining Improvement*.

Reminder: Integrating the 4Ms as a Cycle

While we present the steps as a sequence, in practice steps 2 through 6 are a cycle aligned with the Plan-Do-Study-Act method. As you establish your age-friendly care, you may cycle through these steps many times over the course of several months in order to achieve reliability and then turn your efforts to sustainability and monitoring (quality control) over time.

Appendix A: Age-Friendly Health Systems Advisory Groups and Faculty

Age-Friendly Health Systems Advisory Group

- **Don Berwick, MD, MPP** (co-chair), President Emeritus and Senior Fellow, Institute for Healthcare Improvement; Former Administrator, Centers for Medicare & Medicaid Services
- **Faith Mitchell** (co-chair), PhD, Institute Fellow, Urban Institute
- **Jonathan Perlin, MD** (co-chair), CMO & President Clinical Services, HCA
- **Ann Hendrich, PhD, RN** (founding co-chair), Senior Vice President and Chief Quality/Safety and Nursing Officer, Ascension
- **Mary Tinetti, MD** (founding co-chair), Gladys Phillips Crofoot Professor of Medicine (Geriatrics) and Professor, Institution for Social and Policy Studies; Section Chief, Geriatrics

The complete list of advisors is available on IHI's website.

What Matters Advisory Group

- **Wilma Ballew**
- **Judy Breitstein**
- **Elissa Brown**
- **Jerry Brumbelow**
- **Maryann Brumbelow**
- **U. Clarms**
- **MaeMargaret Evans**
- **Annie Fieldstad**
- **Renee Hill**
- **Marian Hoy**
- **Andrea Kabcenell**
- **Francie LaRue**
- **Dot Malone**
- **Sonia Nahhas**
- **Sherman Pines**
- **Robert Small**
- **Randel Smith**
- **Karen Wright**
- **M. Yzrenee**

Appendix B: Process Walk-Through: Know the 4Ms in Your Health System

There are two key drivers to age-friendly care: knowing about the 4Ms for each older adult in your care ("assess") and incorporating the 4Ms into the plan of care ("act on"). The aim in an Age-Friendly Health System is to reliably assess and act on the 4Ms with all older adults. Just about all systems have integrated some of the 4Ms into care, some of the time, with some older adults, in some places in their systems. The work now is to understand where that is happening and build on that good work so that all 4Ms occur reliably for all older adults in all care settings.

How do you already assess and act on each of the 4Ms in your setting? One way to find out is to spend time in your unit, your practice, or your hospital observing the care. As you do, note your observations to the questions below as you learn more about how the 4Ms are already in practice in your system.

- ☐ What are current activities and services related to each of the 4Ms? What processes, tools, and resources to support the 4Ms do we already have in place here or elsewhere in the system?
- ☐ Where is the prompt or documentation available in the EHR or elsewhere for all clinicians and the care team? Is there a place to see the 4Ms (individually or together) accessible to all team members? Across settings?
- ☐ What experience do your team members have with the 4Ms? What assets do you already have on the team? What challenges have they faced? How have they overcome them?
- ☐ What internal or community-based resources do you commonly refer to, and for which of the 4Ms? For which of the 4Ms do you need additional internal and/or community-based resources?
- ☐ Do your current 4Ms activities and services appear to be having a positive impact on older adults and/or family or other caregivers? Do you have a way to hear about the older adults' experience?
- ☐ Do your current 4Ms activities and services appear to be having a positive impact on the clinicians and staff?
- ☐ Which languages do the older adults and their family or other caregivers speak? Read?
- ☐ Do the health literacy levels, language skills, and cultural preferences of your patients match the assets of your team and the resources provided by your health system?
- ☐ What works well?
- ☐ What could be improved?

4Ms	Specifically, Look for How Do We…	Current Practice and Observations
What Matters: Know and align care with each older adult's specific health outcome goals and care preferences, including, but not limited to, end-of-life care, and across settings of care.	• Ask the older adult What Matters most, document it, and share What Matters across the care team. • Align the care plan with What Matters most.	
Medication: If medication is necessary, use age-friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.	• Review for high-risk medication use and document it. • Deprescribe and dose-adjust high-risk medications, and avoid their use whenever possible.	
Mentation: Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.	**Hospital:** • Screen for delirium at least every 12 hours and document the results. • Ensure sufficient oral hydration. • Orient to time, place, and situation. • Ensure that older adults have their personal adaptive equipment. • Prevent sleep interruptions; use nonpharmacological interventions to support sleep. **Ambulatory:** • Screen for cognitive impairment and document the results. • If cognitive impairment screen is positive, refer for further evaluation and manage manifestations of cognitive impairment. • Screen for depression and document the results. • If depression screen is positive, identify and manage factors contributing to depression, and initiate, or refer out for, treatment.	
Mobility: Ensure that each older adult moves safely every day to maintain function and do What Matters.	• Screen for mobility limitations and document the results. • Ensure early, frequent, and safe mobility.	

Appendix C: Key Actions and Getting Started with Age-Friendly Care — Hospital

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
Ask the older adult What Matters	If you do not have existing questions to start this conversation, try the following, and adapt as needed: *"What do you most want to focus on while you are in the hospital/emergency department for_____ (fill in health problem) so that you can do_____ (fill in desired activity) more often or more easily?"*[2,3,4] For older adults with advanced or serious illness, consider: *"What are your most important goals if your health situation worsens?"*[5]	**Tips** • This action focuses clinical encounters, decision making, and care planning on What Matters most to the older adults. • Consider segmenting your population by healthy older adults, those with chronic conditions, those with serious illness, and individuals at the end of life. How you ask What Matters of each segment may differ. • Consider starting these conversations with *who* matters to the patient. Then ask the patient what their plans are related to life milestones, travel plans, birthdays, and so on in the next six months to emphasize, "I matter, too." Once "who matters" and "I matter, too" are discussed, then *what* matters becomes much easier to discuss. The What Matters Most letter template (Stanford Letter Project) can guide this discussion. • Responsibility for asking What Matters can rest with any member of the care team; however, one person needs to be identified as responsible to ensure it is reliably done. • You may decide to include family members or other caregivers in a discussion about What Matters; however, it is important to also ask the older adult individually. • Ask people with dementia What Matters. Ask people with delirium What Matters at a time when they are suffering least from delirium symptoms. **Additional Resources** • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • The Conversation Project and "Conversation Ready" • Patient Priorities Care • Serious Illness Conversation Guide • Stanford Letter Project • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council)

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
		We recognize that members of different groups have diverse needs. There are resources available that are specific to various communities. For example, the following resources can help to integrate an LGBTQ lens into this action: • Caregiving in the LGBT Community: https://www.lgbtagingcenter.org/resources/resource.cfm?r=883 • Create Your Care Plan: https://www.lgbtagingcenter.org/resources/resource.cfm?r=879 • My Personal Directions: https://www.lgbtagingcenter.org/resources/resource.cfm?r=916 • Advocating for Yourself: https://www.lgbtagingcenter.org/resources/resource.cfm?r=950 • Supporting LGBT People Living with Dementia: • https://www.lgbtagingcenter.org/resources/resource.cfm?r=967 • Issue Brief: LGBT People and Dementia: https://www.lgbtagingcenter.org/resources/resource.cfm?r=945 Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies: https://www.lgbtagingcenter.org/resources/resource.cfm?r=487
Document What Matters	Documentation can be on paper, on a whiteboard, or in the electronic health record (EHR) where it is accessible to the whole care team across settings.[6]	**Tips** • Convert whiteboards to What Matters boards and include information about the older adults (e.g., what name they like to be called, the pronouns they use, favorite foods, favorite activities, what concerns or upsets them, what soothes them, assistive devices, and the names and phone numbers of family members or other caregivers). Identify who on the care team is responsible for ensuring that the information is updated. • Consider documentation of What Matters to the older adult on paper that they can bring to appointments and other sites of care. • Identify where health and health care goals and priorities can be captured in your EHR and available across care teams and settings. • Review What Matters documentation across older adult patients to ensure they are specific to each person (i.e., watch out for generic or the same answers across all patients, which suggests a deeper discussion of What Matters is warranted). **Additional Resources** • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council)

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
Review for high-risk medication use	Specifically, look for: • Benzodiazepines • Opioids • Highly-anticholinergic medications (e.g., diphenhydramine) • All prescription and over-the-counter sedatives and sleep medications • Muscle relaxants • Tricyclic antidepressants • Antipsychotics[7,8,9]	**Tips** • If you decide to limit the number of medications to focus on, identify those most frequently dispensed in your hospital or unit, or those for which there is a champion to deprescribe. **Additional Resources** • American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults • AGS 2019 Beers Criteria Pocketcard • Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines
Screen for delirium at least every 12 hours	If you do not have an existing tool, try using Ultra-Brief 2-Item Screener (UB-2).[10,11]	**Tips** • Decide on the tool that best fits your care team culture. • Be aware that low prevalence rates of delirium before the 4Ms are in place may indicate inaccurate use of a screening or assessment tool. • It is critical to use any tool only as instructed and to do ongoing training (yearly competency) to make sure it is being used correctly. • Ask questions in a way that emphasizes the older adults' strengths (e.g., "Please tell me the day of the week" rather than "Do you know what day it is today?"). • Educate family members or other caregivers on the signs of delirium and enlist their support to alert the care team to any changes as soon as they notice them. Ask them if their loved one seems "like themselves." • Document mental status in the chart to measure changes shift-to-shift. • Until ruled out, consider a change in mental status to be delirium and raise awareness among care team and family members or other caregivers about the risk of delirium superimposed on dementia. • Note: Delirium has an underlying cause and is preventable and treatable in most cases. Care teams need to: 1. Remove or treat underlying cause(s) if it occurs 2. Restore or maintain function and mobility 3. Understand delirium behaviors 4. Prevent delirium complications

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
		Additional Resources • Confusion Assessment Method (CAM) and its variations: 3D-CAM for medical-surgical units, CAM-ICU for intensive care units, bCAM for emergency departments • Nursing Delirium Screening Scale (Nu-DESC) • Hospital Elder Life Program (HELP) • www.idelirium.org
Screen for mobility limitations	If you do not have an existing tool, try using Timed Up & Go (TUG).[12,13]	**Tips** • Recognize that older adults may be embarrassed or worried about having their mobility screened. • Underscore that a mobility screen allows the care team to know the strengths of the older adult. **Additional Resources** • Johns Hopkins – Highest Level of Mobility (JH-HLM) Scale • Performance-Oriented Mobility Assessment (POMA)[14]

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
Align the care plan with What Matters	Incorporate What Matters into the goal-oriented plan of care and align the care plan with the older adult's goals and preferences[15,16,17] (i.e., What Matters).	**Tips** • Health outcome goals are the activities that matter most to an individual, such as babysitting a grandchild, walking with friends in the morning, or continuing to work as a teacher. Health care preferences include the medications, health care visits, testing, and self-management tasks that an individual is able and willing to do. • When you focus on the patient's priorities, Medication, Mentation, and Mobility usually come up so the patient can do more of What Matters. • Consider how care while in the hospital can be modified to align with What Matters. • Consider What Matters to the older adult when deciding to where they will be discharged. • Use What Matters to develop the care plan and navigate trade-offs. For example, you may say, "There are several things we could do, but knowing what matters most to you, I suggest we…" • Use the patient's priorities (not just diseases) in communicating, decision making, and assessing benefits. • Use collaborative negotiations; agree there is no best answer and brainstorm alternatives together. For example, you may say, "I know you don't like the CPAP mask, but are you willing to try it for two weeks to see if it helps you be less tired, so you can get back to volunteering, which you said was most important to you?" • Care options likely involve input from many disciplines (e.g., physical therapy, social work, community organizations, and so on). **Additional Resources** • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • Patient Priorities Care • Serious Illness Conversation Guide • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council)
Deprescribe or do not prescribe high-risk medications**	Specifically avoid or deprescribe the high-risk medications listed below. • Benzodiazepines • Opioids	**Tips** • These medications, individually and in combination, may interfere with What Matters, Mentation, and safe Mobility of older adults because they increase the risk of confusion, delirium, unsteadiness, and falls.[23] • Deprescribing includes both dose reduction and medication discontinuation. • Deprescribing is a positive, patient-centered approach, requiring informed patient consent, shared decision making, close monitoring, and compassionate support.

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**

	• High-anticholinergic medications (e.g., diphenhydramine)
	• All prescription and over-the-counter sedatives and sleep medications
	• Muscle relaxants
	• Tricyclic antidepressants
	• Antipsychotics[18,19,20,21]
	
	If the older adult takes one or more of these medications, discuss any concerns the patient may have, assess for adverse effects, and discuss deprescribing with the older adult.[22]
		• When possible, avoid prescribing these high-risk medications (prevention); consider changing order sets in the EHR to change prescribing patterns (e.g., adjust/reduce doses, change medications available).
		• Your institution should have delirium and falls prevention and management protocols that include guidance to avoid high-risk medications.
		• Offer nonpharmacological options to support sleep and manage pain.
		• Upon discharge, do not assume all medications should be sustained. Remove medications the older adult can stop taking upon discharge.
		• Include a medication list printout as part of standard check-out steps and ensure that the older adult and family or other caregivers understand what their medications are for, how to take them, why they are taking them, and how to monitor whether they are helping or possibly causing adverse effects.
		• Inform the patient's ambulatory clinicians of medication changes.
		• Consult pharmacy.
		• When instituting an age-friendly approach to medications:
		  ○ Identify who on your team is going to be the champion of this "M." The champion may not be a pharmacist, but it is vital to have a pharmacist or physician, as well as a patient, work on the plan.
		  ○ Review your setting or system's data, if possible, to identify medications that may be high-risk (e.g., anticoagulants, insulin, opioids) or potentially inappropriate (e.g., anticholinergics).
		  ○ Determine your goal(s) with respect to your medication(s) identified in the previous step.
		  ○ Conduct a series of PDSA cycles to achieve your goal(s).
		
		Additional Resources
		
		• deprescribing.org
		• Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines
		• Alternative Medications for Medications Included in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug–Disease Interactions in the Elderly Quality Measures
		• HealthinAging.org provides expert health information for older adults and caregivers about critical issues we all face as we age
		• Crosswalk: Evidence-Based Leadership Council Programs and the 4Ms

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
Ensure sufficient oral hydration**	Identify a target amount of oral hydration appropriate for the older adult and monitor to confirm it is met.	**Tips** • Ensure that water and other patient-preferred, noncaffeinated fluids are available at the bedside and accessible to the older adult. • The focus here is on oral hydration so that the patient is not on an IV that may interfere with Mobility. • Establish a delirium prevention and management protocol that includes oral hydration. • Replace pitchers with straw water bottles for easier use by older adults.
Orient older adults to time, place, and situation**	Make sure day and date are updated on the whiteboard. Provide an accurate clock with large face visible to older adults. Consider using tools such as an "All About Me" board or poster/card that shows what makes the older adults calm and happy, who is important to them, names of pets, etc. Make newspapers and periodicals available in patient rooms. Invite family or other caregivers to bring familiar and orienting items from home (e.g., family pictures).	**Tips** • For older adults with dementia, consider gentle re-orientation or use of orienting cues; avoid repeated testing of orientation if the older adult appears agitated.[24] • Conduct orientation during every nursing shift. • Establish a delirium prevention and management protocol that includes orientation. • Identify person-centered environmental and personal approaches to orienting the older adult.
Ensure older adults have their personal adaptive equipment**	Incorporate routine intake and documentation of the older adults' personal adaptive equipment. At the start of each shift, check for sensory aides and offer to clean them. If needed, offer a listening device or hearing amplifier from the unit.	**Tips** • Personal adaptive equipment includes glasses, hearing aids, dentures, and walkers. • Establish a delirium prevention and management protocol that includes personal adaptive equipment. • Note use of personal adaptive equipment on the whiteboard. • Confirm need for personal adaptive equipment with family or other caregivers.

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
Prevent sleep interruptions; use nonpharmacological interventions to support sleep**	Avoid overnight vital checks and blood draws unless absolutely necessary. Create and use sleep kits[25,26] that include items such as a small CD player, CD with relaxing music, lotion for a backrub or hand massage, noncaffeinated tea, lavender, sleep hygiene educational cards (e.g., no caffeine after 11:00 AM or promote physical activity). These can be placed in a box on the unit to use in patient rooms as needed.	**Tips** • Nonpharmacological sleep aids include earplugs, sleeping masks, muscle relaxation such as hand massage, posture and relaxation training, white noise and music, and educational strategies. • Your institution should have a delirium prevention and management protocol that includes nonpharmacological sleep support. • Make a sleep kit available for order in the EHR. • Engage family or other caregivers to support sleep with methods that are familiar to the older adult.

Ensure early, frequent, and safe mobility[27,28,29]	Ambulate three times a day.
	
	Set and meet a daily mobility goal with each older adult.
	
	Get patients out of bed or have them leave the room for meals.
		Tips
		• Assess and manage impairments that reduce mobility; for example:
		  ○ Manage pain
		  ○ Assess impairments in strength, balance, or gait
		  ○ Remove catheters, IV lines, telemetry, and other tethering devices as soon as possible
		  ○ Avoid restraints
		  ○ Avoid sedatives and drugs that immobilize the older adult
		• Refer to physical therapy; have physical therapy interventions to help with balance, gait, strength, gait training, or an exercise program if needed.
		• Establish a delirium prevention and management protocol that includes mobility.
		• Engage the older adult and family or other caregivers directly by offering exercises that can be done in bed (e.g., put appropriate exercises on a placemat that remains in the room).
		
		Additional Resources
		• Hospital Elder Life Program (HELP) Mobility Change Package and Toolkit

**These activities are also key to preventing delirium[30] and falls.

Appendix D: Key Actions and Getting Started with Age-Friendly Care — Ambulatory/Primary Care

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
Ask the older adult What Matters	If you do not have existing questions to start this conversation, try the following, and adapt as needed. *"What is the one thing about your health or health care you most want to focus on related to_____ (fill in health problem OR the health care task) so that you can do_____ (fill in desired activity) more often or more easily?"*[31,32,33] For older adults with advanced or serious illness, consider: *"What are your most important goals if your health situation worsens?"*[34]	**Tips** • This action focuses clinical encounters, decision making, and care planning on What Matters most to older adults. • Consider segmenting your population by healthy older adults, those with chronic conditions, those with serious illness, and individuals at the end of life. How you ask What Matters of each segment may differ. • Consider starting these conversations with *who* matters to the patient. Then ask the patient what their plans are related to life milestones, travel plans, birthdays, and so on in the next six months to emphasize, "I matter too." Once "who matters" and "I matter too" are discussed, then *what* matters becomes much easier to discuss. The What Matters Most letter template (Stanford Letter Project) can guide this discussion. • Responsibility for asking What Matters can rest with any member of the care team; however, one person needs to be identified as responsible to ensure it is reliably done. • You may decide to include family or other caregivers in a discussion about What Matters; however, it is important to also ask the older adult individually. • Ask people with dementia What Matters. • Integrate asking What Matters into the Welcome to Medicare and Medicare Annual Wellness Visit. • You may include What Matters questions in pre-visit paperwork and verify the answers during the visit. **Additional Resources** • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • The Conversation Project and "Conversation Ready" • Patient Priorities Care • Serious Illness Conversation Guide • Stanford Letter Project • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council) • End-of-Life Care Conversations: Medicare Reimbursement FAQs

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
Document What Matters	Documentation can be on paper or in the electronic health record (EHR) where it is accessible to the whole care team across settings[35]	**Tips** • Identify where health and health care goals and priorities can be captured in your EHR and available across care teams and settings. • Consider documentation of What Matters to the older adult on paper that they can bring to appointments and other sites of care. • Invite older adults to enter What Matters to them on your patient portal. **Additional Resources** • MY STORY© • Community Library for your EHR • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council)
Review for high-risk medication use	Specifically, look for: • Benzodiazepines • Opioids • Highly-anticholinergic medications (e.g., diphenhydramine) • All prescription and over-the-counter sedatives and sleep medications • Muscle relaxants • Tricyclic antidepressants • Antipsychotics[36,37,38]	**Tips** • Consider this review a medication risk assessment and be sure to include over-the-counter medications at least annually. • Engage the older adult and family member or other caregiver in providing all medications (including over-the-counter medicines) for review. • Medicare beneficiaries may be eligible for an annual comprehensive medication review. • Medication reconciliation, part of the Medicare Annual Wellness Visit, may be an important step in identifying high-risk medications. **Additional Resources** • American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults • AGS 2019 Beers Criteria Pocketcard • Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines • Medicare Interactive, Annual Wellness Visit • CDC Medication Personal Action Plan • CDC Personal Medicines List

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
Screen for dementia / cognitive impairment	If you do not have an existing tool, try using the Mini-Cog©[39]	**Tips** • Normalize cognitive screening for patients. For example, say "I'm going to assess your cognitive health like we check your blood pressure, or your heart and lungs." • Emphasize an older adult's strengths when screening and document it so that all providers have a baseline cognitive screen. • If they have a sudden change (day, weeks) in cognition, consider and rule out delirium. • Screening for cognitive impairment is part of Welcome to Medicare and the Medicare Annual Wellness Visit. **Additional Resources** • Saint Louis University Mental Status (SLUMS) Exam • Montreal Cognitive Assessment (MoCA)
Screen for depression	If you do not have an existing tool, try using the Patient Health Questionnaire – 2 (PHQ-2).[40]	**Tips** • Screen if there is concern for depression. • Screening for depression is part of Welcome to Medicare and the Medicare Annual Wellness Visit. **Additional Resources** • Patient Health Questionnaire – 9 (PHQ-9) • Geriatric Depression Scale (GDS) and GDS: Short Form
Screen for mobility limitations	If you do not have an existing tool, try using Timed Up & Go (TUG).[41,42]	**Tips** • Recognize that older adults may be embarrassed or worried about having their mobility screened. • Underscore that a mobility screen allows the care team to know the strengths of the older adult. • Screening for mobility is part of Welcome to Medicare and the Medicare Annual Wellness Visit. • Considering engaging the full care team in assessing mobility. Does the person walk into the waiting room? Are they able to stand up from the waiting room chair when called? Can they walk to the exam room? • Consider also conducting a functional assessment. Common tools include: ○ Barthel Index of ADLs (in EPIC)

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**
		○ The Lawton Instrumental Activities of Daily Living (IADL) Scale ○ Katz Index of Independence in Activities of Daily Living (ADL) **Additional Resources** • Johns Hopkins – Highest Level of Mobility (JH-HLM) Scale • Performance-Oriented Mobility Assessment (POMA)[43]

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
Align the care plan with What Matters	Incorporate What Matters in the goal-oriented plan of care and align the care plan with the older adult's goals and preferences[44,45,46] (i.e., What Matters).	**Tips** • Health outcome goals are the activities that matter most to an individual, such as babysitting a grandchild, walking with friends in the morning, or continuing to work as a teacher. Health care preferences include the medications, health care visits, testing, and self-management tasks that an individual is able and willing to do. • When you focus on the patient's priorities, Medication, Mentation (cognition and depression), and Mobility usually come up so the patient can do more of What Matters. • Use What Matters to develop the care plan and navigate trade-offs. For example, you may say, "There are several things we could do, but knowing what matters most to you, I suggest we…" • Consider the patient's priorities (not just diseases) in communicating, decision making, and assessing benefits. • Use collaborative negotiations; agree there is no best answer and brainstorm alternatives together. For example, you may say, "I know you don't like the CPAP mask, but are you willing to try it for two weeks to see if it helps you be less tired, so you can get back to volunteering, which you said was most important to you?" • Care options likely involve input from many disciplines (e.g., physical therapy, social work, community organizations, and so on).

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
		Additional Resources • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • Patient Priorities Care • Serious Illness Conversation Guide • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council)

Deprescribe or avoid prescribing high-risk medications**	Specifically avoid or deprescribe the high-risk medications listed below:
	• Benzodiazepines
	• Opioids
	• High-anticholinergic medications (e.g., diphenhydramine)
	• All prescription and over-the-counter sedatives and sleep medications
	• Muscle relaxants
	• Tricyclic antidepressants
	• Antipsychotics[47,48,49,50]
	If the older adult takes one or more of these medications, discuss any concerns the patient may have, assess for adverse effects, and discuss deprescribing with the older adult.[51]
		Tips
		• These medications, individually and in combination, may interfere with What Matters, Mentation, and safe Mobility of older adults because they increase the risk of confusion, delirium, unsteadiness, and falls.[52]
		• Deprescribing includes both dose reduction and medication discontinuation.
		• Deprescribing is a positive, patient-centered approach, requiring informed patient consent, shared decision making, close monitoring, and compassionate support.
		• When possible, avoid prescribing these high-risk medications (prevention). Consider changing order sets in the EHR to change prescribing patterns (e.g., adjust/reduce doses or change medications available).
		• Provide ongoing patient/caregiver education about potentially high-risk medications through all care settings (e.g., outpatient pharmacy) to help improve safe medication use and informed decision making.
		• Consider community resources to support pain management with nonpharmacological interventions, including referral to community-based resources.
		• Communicate changes in medications across clinicians and settings of care, and with the primary pharmacy working with the older adult.
		• When instituting an age-friendly approach to medications:
		  ○ Identify who on your team is going to be the champion of this "M." The champion may not be a pharmacist, but it is vital to have a pharmacist or physician, as well as a patient, work on the plan.
		  ○ Review your setting or system's data, if possible, to identify medications that may be high-risk (e.g., anticoagulants, insulin, opioids) or potentially inappropriate (e.g., anticholinergics)
		  ○ Determine your goal(s) with respect to your medication(s) identified in the previous step.
		  ○ Conduct a series of PDSA cycles to achieve your goal(s).

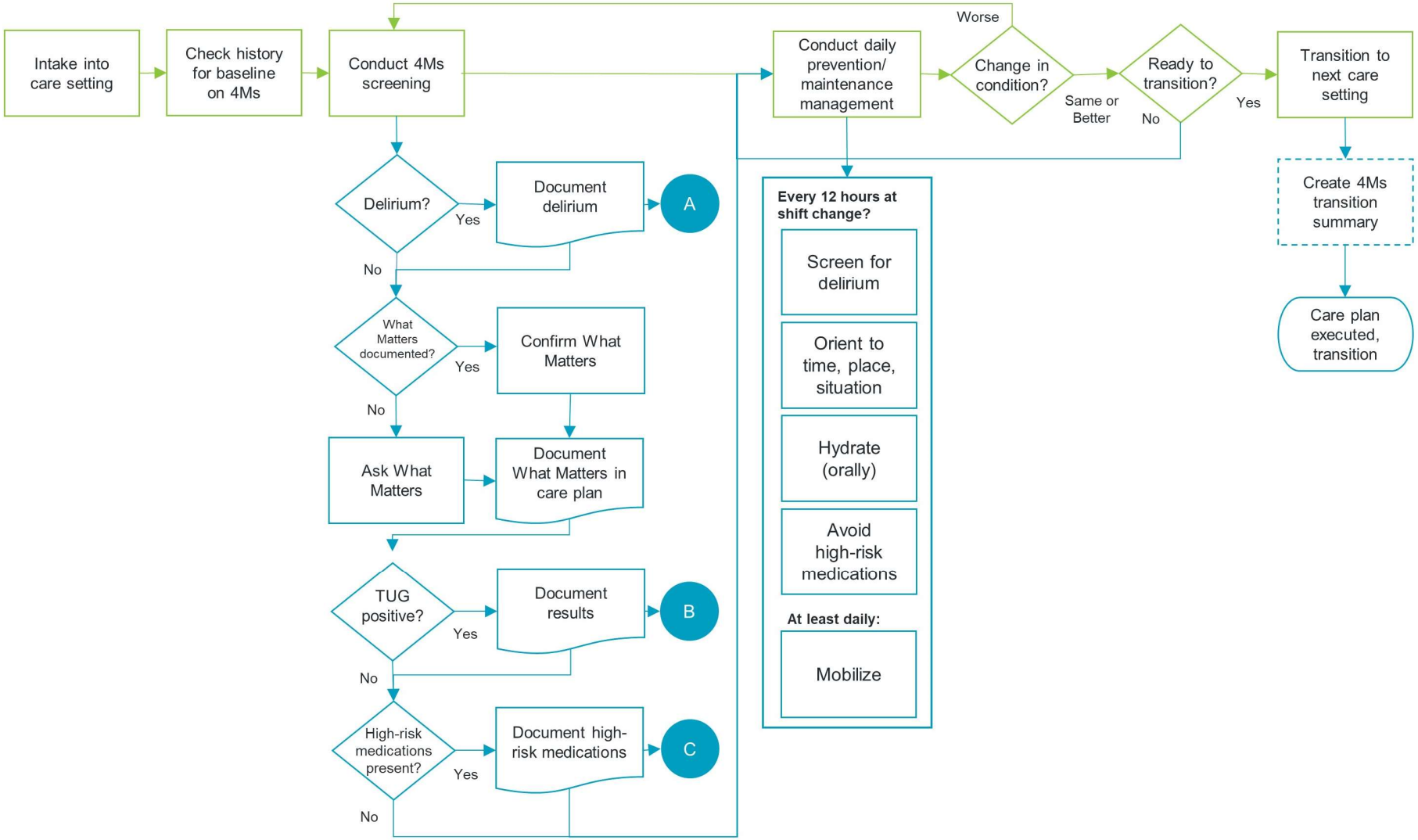
Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
		Additional Resources • deprescribing.org • Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines • Alternative Medications for Medications Included in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug–Disease Interactions in the Elderly Quality Measures • HealthinAging.org (expert health information for older adults and caregivers about critical issues we all face as we age) • Crosswalk: Evidence-Based Leadership Council Programs and the 4Ms
Consider further evaluation and manage manifestations of dementia, or refer to geriatrics, psychiatry, or neurology	Share the results with the older adult and caregiver. Assess for modifiable contributors to cognitive impairment. Consider further diagnostic evaluation if appropriate. Follow current guidelines for treatment of dementia and resulting behavioral manifestations OR refer to geriatrics, psychiatry, or neurology for management of dementia-related issues. Provide educational materials to the older adult and family member or other caregiver. Refer the older adult, family, and other caregivers to supportive resources, such as the Alzheimer's Association.[53]	**Tips** • Know about and refer older adults and their caregivers to local community-based organizations and resources to support them with education and/or support. • Include family caregivers. They provide a source of information and support. To identify these individuals, ask the older adult, "Who would you go to for help?" and recommend they bring that person to the next visit. • Consider also assessing and managing caregiver burden. • Ensure follow-through on any referrals. • If a memory disturbance is found, avoid medications that will make cognitive health worse. • If there is a diagnosis of dementia, include it on the problem list. If not, include cognitive impairment. • Do not prescribe medications that can exacerbate cognitive impairment, such as benzodiazepines and anticholinergics. • Older adults with dementia will be at high risk of delirium, especially if hospitalized, so educate family or other caregivers and providers on delirium prevention. **Additional Resources** • Local Area Agency on Aging • Community Resource Finder • Zarit Burden Interview (for caregivers)

Act on: Incorporate the 4Ms into the Plan of Care		
Key Actions	**Getting Started**	**Tips and Resources**
Identify and manage factors contributing to depression	Identify and manage factors that contribute to depressive symptoms, including sensory limitations (vision, hearing), social isolation, losses associated with aging (job, income, societal roles), bereavement, and medications. Consider the need for counseling and/or pharmacological treatment of depression, or refer to a mental health provider if appropriate.	**Tips** • Educate the patient and caregiver about depression in older adults. • Recognize social isolation as a risk factor for depression and identify community-based resources that support social connections. **Additional Resources** • Your local Area Agency on Aging • Crosswalk: Evidence-Based Leadership Council Programs and the 4Ms

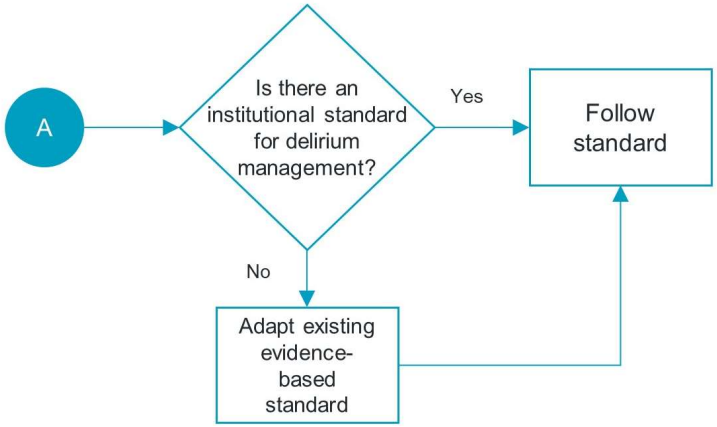
Ensure safe mobility[54,55,56]	Assess and manage impairments that reduce mobility; such as:
	• Pain
	• Impairments in strength, balance, or gait
	• Hazards in home (e.g., stairs, loose carpet or rugs, loose or broken handrails)
	• High-risk medications
	
	Refer to physical therapy.
	
	Support older adults, families, and other caregivers to create a home environment that is safe for mobility.[57]
	
	Support older adults to identify and set a daily mobility goal that supports What Matters.
	
	Review and support progress toward the mobility goal in subsequent interactions.
		Tips
		• Have a multifactorial falls prevention protocol (e.g., STEADI) that includes:
		  ○ Educating the patient/family/other caregivers
		  ○ Managing impairments that reduce mobility (e.g., pain, balance, gait, strength)
		  ○ Ensuring a safe home environment for mobility
		  ○ Identifying and setting a daily mobility goal with the patient that supports What Matters, and then review and support progress toward the mobility goal
		  ○ Avoiding high-risk medications
		  ○ Referring to physical therapy
		
		Additional Resources
		• Stopping Elderly Accidents, Deaths & Injuries (STEADI)
		• CDC My Mobility Plan

Appendix E: Age-Friendly Care Workflow Examples

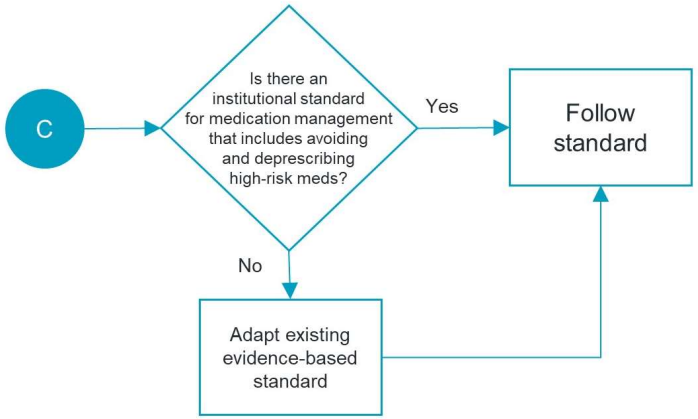
Hospital-Based Care Workflows: Core Functions



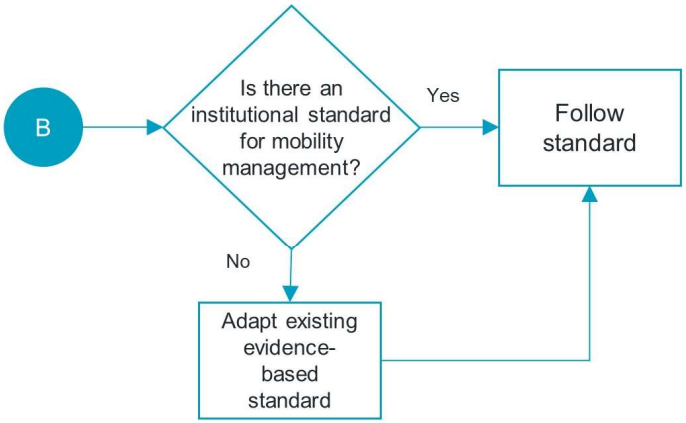
Delirium Workflow



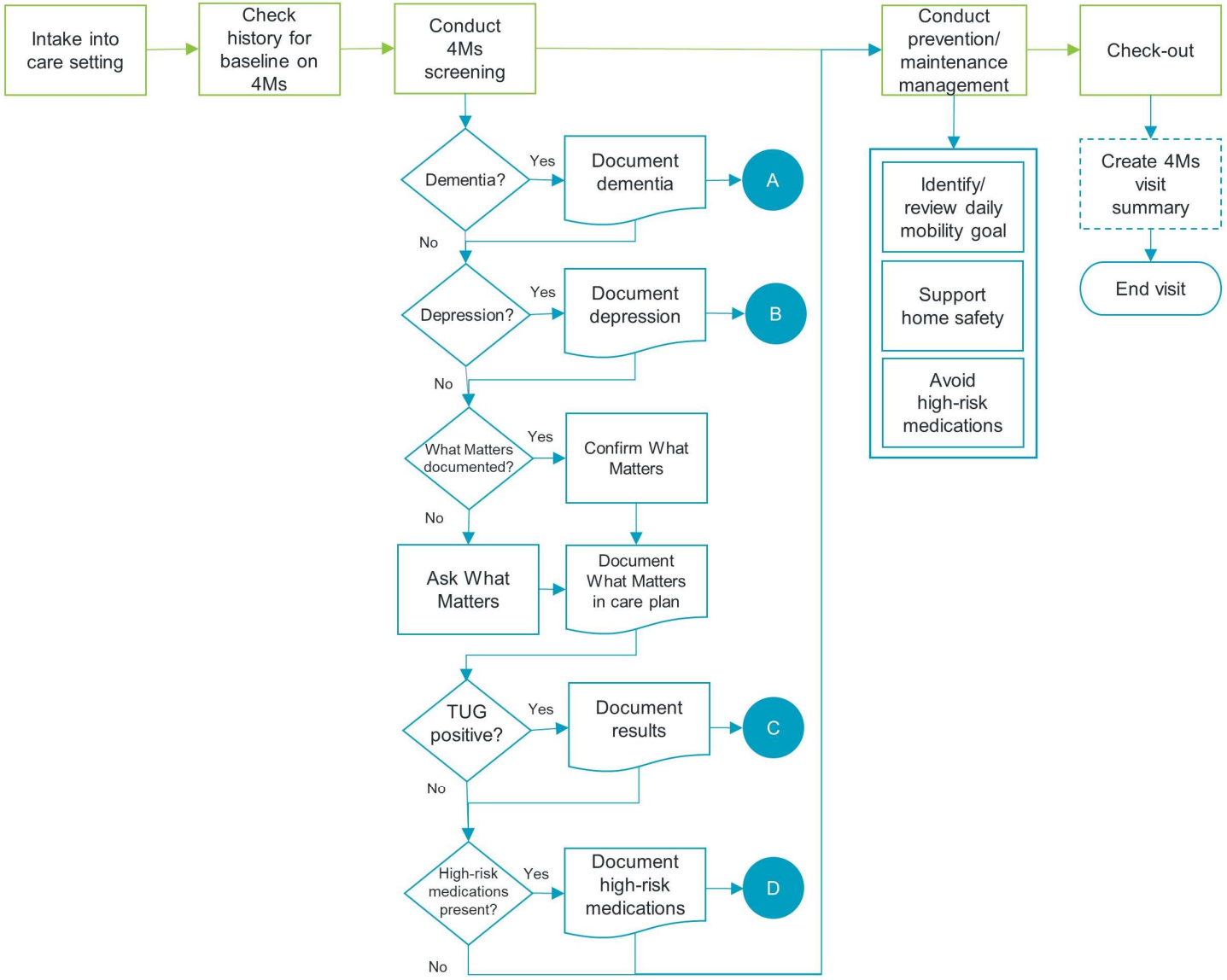
Medication Management Workflow



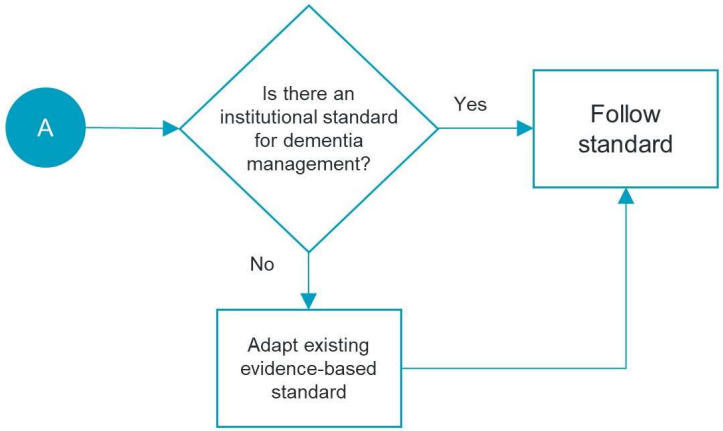
Mobility Workflow



Ambulatory/Primary Care Workflows:
Core Functions for New Patient, Annual Visit, or Change in Health Status



Dementia Workflow



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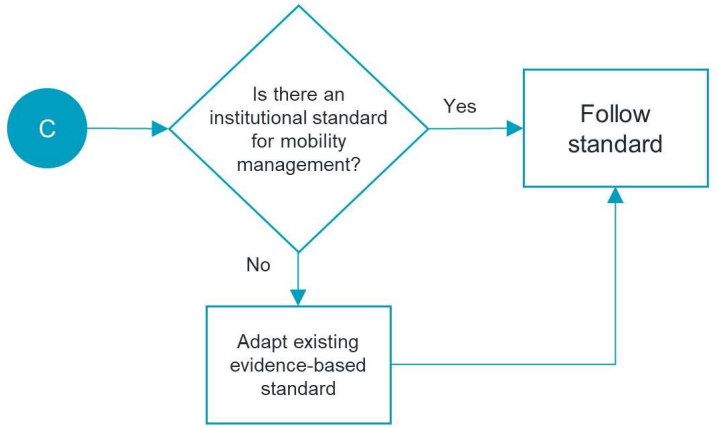
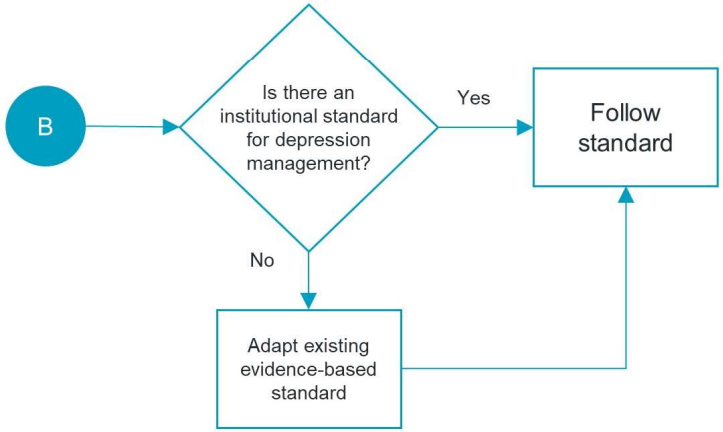
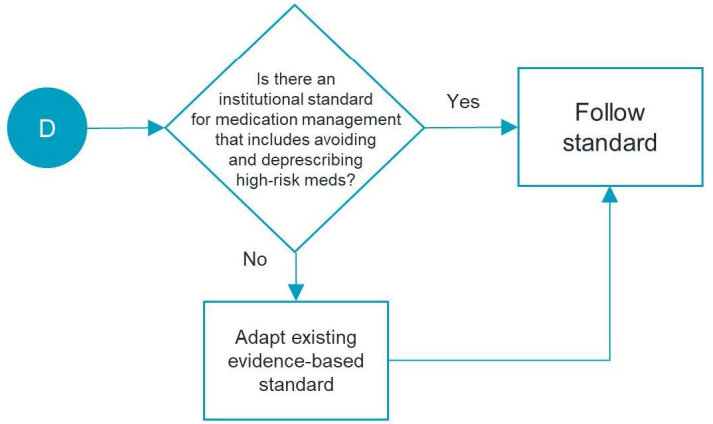


Depression Workflow



Medication Management Workflow



Appendix F: Examples of PDSA Cycles for Age-Friendly Care

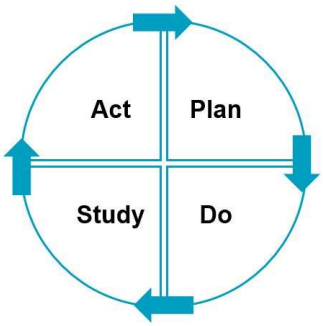
Example: Testing What Matters Engagement with Hospitalized Older Adult Patients

Plan-Do-Study-Act Record

NAME OF HEALTH SYSTEM: Camden University Medical Center

NAME OF PERSON COMPLETING FORM: Erin Rush, RN

DATE: March 29, 2019



Change Idea to ____develop or _X_ test or ____ implement

Description:

Cycle 1: Test a What Matters engagement with a hospitalized patient.

Essential Ingredients

PLAN:

Questions: What do we want to know?

- Can physicians incorporate What Matters engagements into rounds with older adult patients?
- Will physicians learn something useful from this What Matters engagement relevant to care planning?

Predictions: What do we think will happen?

- Physicians can incorporate What Matters engagements into rounds with older adult patients.
- Physicians can learn something useful from What Matters engagements relevant to care planning.

Plan for the change or test: Who, What, When, Where. What are we going to do to make our test happen?

List the tasks necessary to complete this test (what)	Person responsible	When	Where
Orient Dr. M (hospitalist) to this test	Erin	Monday morning	4 South
Select older adult patient for test	Erin and Dr. M	Monday morning	4 South
Ask older adult patient, "What's important to you in the next few days as you recover from your illness?"	Dr. M	Monday	TBD
Debrief test and complete PDSA cycle	Erin and Dr. M	Tuesday morning	4 South

Plan for data collection: Who, What, When, Where. How will we compare predictions to actual?

Erin and Dr. M to meet the next day to debrief test, capture what happened, impressions, how that compared to predictions, next steps.

DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened.

- Dr. M asked 1, and then 4 more, older patients — went beyond testing with just 1 patient!
- Some answers were very health/condition related (e.g., a patient with shortness of breath/cough stated, "I just want my cough to be better and to be able to breathe.").
- Other answers were more life related, for example:
  - A patient being treated for stroke, who is a performance artist, shared a video of performance and indicated what matters is to be able to return to performing.
  - A patient with multiple falls wants to be able to stand to cook again.

STUDY: Complete analysis of data; summarize what was learned; compare what happened to predictions above.

- Asking a single question is not sufficient. Need the opportunity for follow-up questions and listening.
  For example: A patient with congestive heart failure and arthritis has an immediate goal to reduce swelling in her legs. Further probing revealed a desire to stay in her home and be able to cook to avoid delivered salty foods and to avoid rehospitalization. Possible solution: Prescription for homemaker assistance.
- Dr. M regularly engages patients with What Matters in an outpatient setting. New for inpatient rounds, but feasible to include.
- Worthwhile if there is time for follow-up (not just one question and one answer in 30 seconds).
- No patients responded with goals or needs that could not be addressed somehow in the care plan.
- Asking a What Matters question feels awkward. Need to build a relationship first before asking an "intimate" question. For example, asking on the second day of rounding feels better than asking on the first day.
- Asking a What Matters question helped Dr. M bond with the patients.
- There was a lack of clarity on what to do with the information learned from the What Matters engagement (e.g., how to document, how to share).
- Still have a concern about not knowing what to do if a patient expresses a need or goal beyond the specific health condition or issues that the physician (Dr. M) is trained to address.

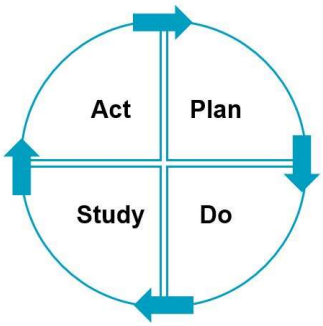
ACT: Are we ready to make a change? Plan for the next cycle.

Test again. Questions to explore through more testing include:

- Is it better to ask the What Matters question at the beginning or end of the encounter?
- How can we get at What Matters for our patients with cognitive impairment?
- Where is the best place to document the information from the What Matters engagement?
  - Whiteboard: "Anyone" can use the whiteboard. Can this be done effectively?
  - Epic documentation agreement (meetings underway with Epic team to discuss options).
- Are the daily multidisciplinary rounds/huddles the best place to discuss what's learned from What Matters engagements?
  - Do we need to coordinate our engagement about What Matters? Nursing, care management, and physicians all could be asking variants of What Matters.
- Could the nurse or case manager have a What Matters conversation and document it so that it is available for physicians to reference in a consult visit or rounding?

Example: Testing a 4Ms Screening for Older Adults in Primary Care

Plan-Do-Study-Act Record	**NAME OF HEALTH SYSTEM:** Name **NAME OF PERSON COMPLETING FORM:** Name **DATE:** Date

	**Change Idea to ____develop or _X_ test or ____ implement**
	
	Description:
	Cycle 1: Test a 4Ms "screening set" with one older adult patient in your care.
	• What Matters:
	  ○ Ask, "What makes life worth living?"; "What would make tomorrow a really great day for you?"; "What concerns you most when you think about your health and health care in the future?"
	  ○ Confirm the presence of a health care proxy (proxy's name, contact information)
	• Medication:
	  ○ Identify use of high-risk medications
	• Mentation:
	  ○ Administer the Mini-Cog
	  ○ Administer the PHQ-2
	• Mobility:
	  ○ Conduct the TUG Test

PLAN:

Questions: What do we want to know? [Add or edit questions below, as needed.]

1. Can we practice all 4Ms items (above) on intake for one older adult patient?
2. How long does it take?
3. How does it feel for the staff conducting the assessment? (e.g., What went well? What could be improved?)
4. How does it feel for the patient/family receiving the assessment? (e.g., What went well? What could be improved?)
5. What are we learning from conducting this 4Ms screening set? Did we learn anything about this patient that will improve our care, service, and/or processes?

Predictions: What do we think will happen? [Edit draft answers below, as needed.]

1. Yes
2. 10 minutes
3. Staff will give at least two ideas/identify two issues with the 4Ms screening set.
4. Patient/family will give at least one idea/issue with the screening set use.
5. Staff will get at least one insight/"aha" regarding care for the patient from the screening set.

Plan for the change or test: Who, What, When, Where. What are we going to do to make our test happen? [Edit the draft tasks below, as needed.]

List the tasks necessary to complete this test (What)	Person responsible	When	Where
1. Select an older adult patient with whom we are likely to be able to conduct this test in the next 3 days. Identify a patient who we might "easily" engage on all items of the 4Ms screening set.			

2. Select a staff person who will conduct the test, and brief her/him.			
3. Decide on what you will say to invite the patient/family to participate in testing the 4Ms screening set. For example, "We are testing ways to know our patients better to develop the right care plan. Would you be willing to test a set of questions today and give your opinion about this experience?"			

Plan for data collection: Who, What, When, Where. How will we compare predictions to actual? [Adapt or edit the sample data collection form below, as needed.]

- Fill in data collection plan (Who, What, When, Where) [example below]:

4Ms Screening Set Test: NAME OF HEALTH SYSTEM													
4Ms Screening Set Test: NAME OF CONTACT PERSON		Patient 1		Patient 2		Patient 3		Patient 4		Patient 5		Patient 6	
Date													
What Matters	Asked: What makes life worth living? (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Asked: What would make tomorrow a really great day for you? (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Asked: What concerns you most when you think about your health and health care in the future? (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Has health care agent? (yes/no/didn't review)	Y	N DR	Y	N DR	Y	N DR	Y	N DR	Y	N DR	Y	N DR
Medication	Identified use of high-risk medication (yes/no/didn't review)	Y	N DR	Y	N DR	Y	N DR	Y	N DR	Y	N DR	Y	N DR
Mentation	Administered the Mini-Cog (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Administered the PHQ-2 (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Mobility	Conducted TUG Test (yes/no)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Amount of time to complete													
Staff feedback													
Patient/family feedback													
Other notes and/or questions that came up from this test													

DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened.

- Fill in during or after conducting the test

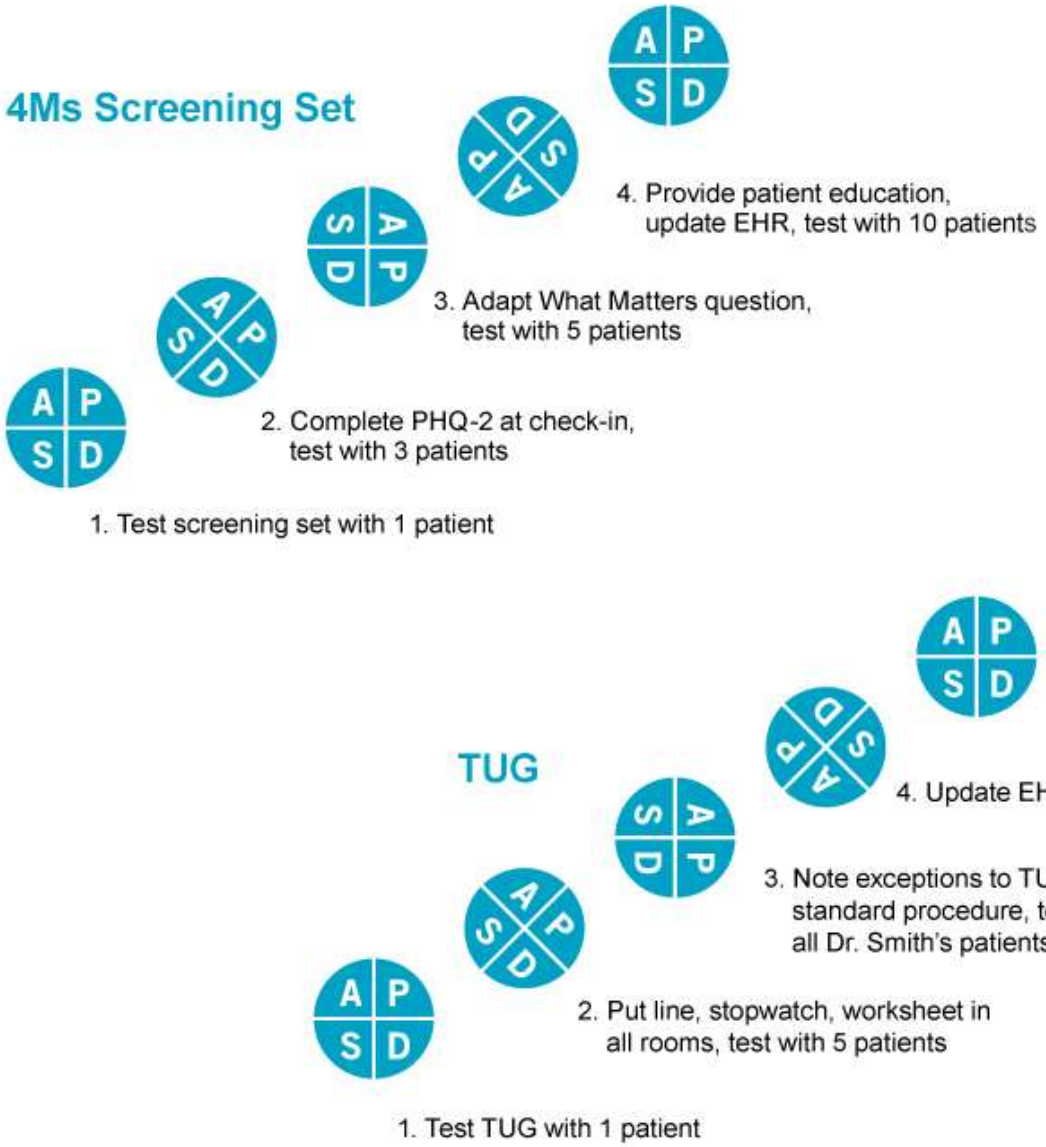
STUDY: Complete analysis of data; summarize what was learned; compare what happened to predictions above.

- Fill in after conducting the test

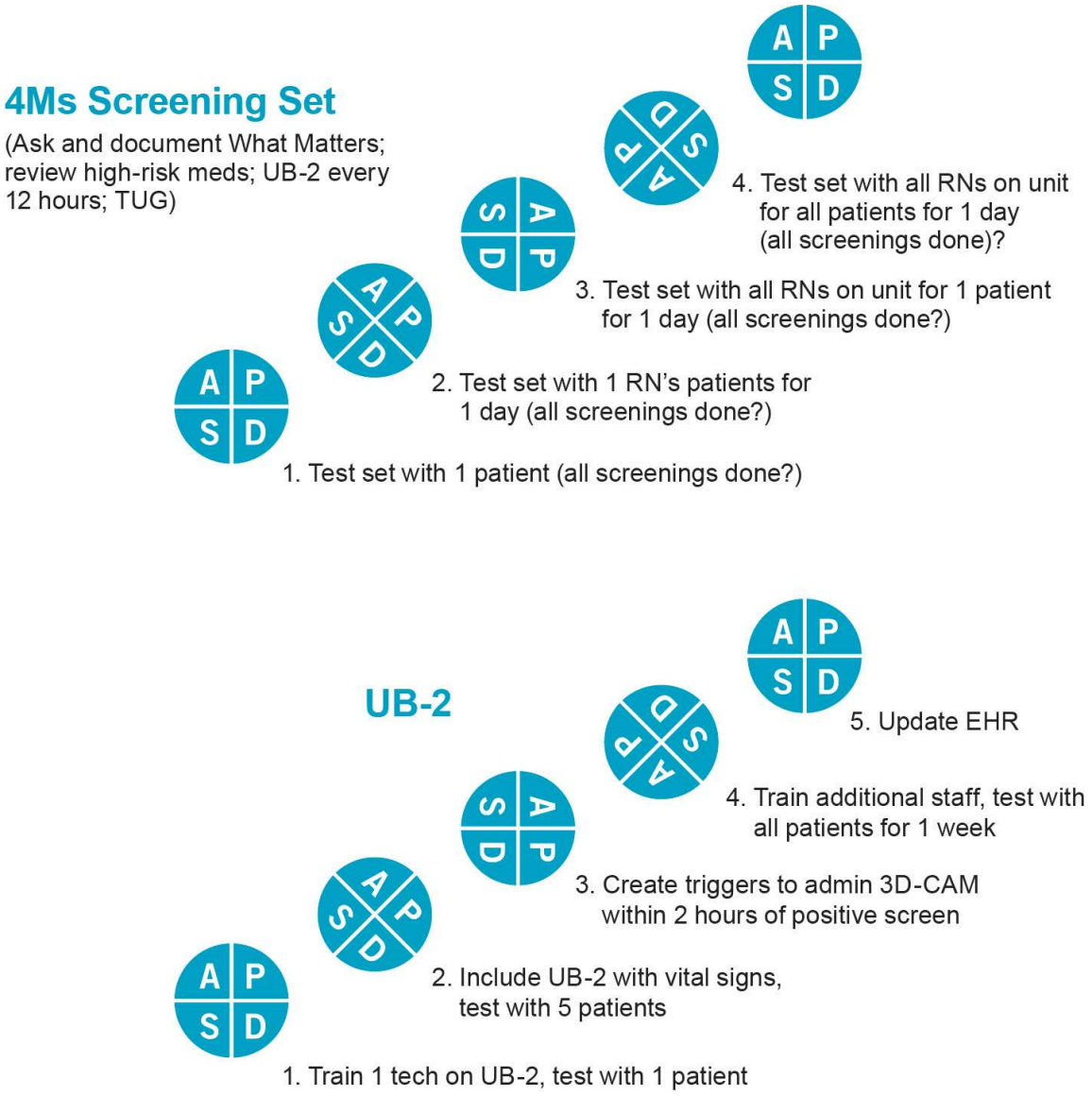
ACT: Are we ready to make a change? Plan for the next cycle.

- Fill in after conducting the study. Will you adopt, adapt, abandon, or run the test again? For example, PDSA cycle 2: Conduct test again with 5 patients making the following adjustments…

Example: Ambulatory/Primary Care Multiple PDSA Cycles



Example: Hospital-Based Care Multiple PDSA Cycles



Appendix G: Implementing Reliable 4Ms Age-Friendly Care

The goal is to reliably integrate the 4Ms into the way you provide care for every older adult, in every setting, every time. How will you know that 4Ms care, as described by your site, is reliably in place?

The best way is to observe the work directly, using the 4Ms Age-Friendly Care Description Worksheet as an observation guide. Another way is to review patient records to confirm completeness of 4Ms documentation and alignment of care team actions with information obtained in assessment. Note that you only need a handful of patient records to tell you that your 4Ms performance is not at a high level (say, 95 percent or higher).[58] For example, if you see three instances of incomplete 4Ms care in a random sample of 10 records, you have strong evidence that your system is not performing in a way that 95 percent or more of your patients are experiencing 4Ms care.

If IHI visited your care setting, we also would look for several kinds of evidence that your site has the foundation for reliable 4Ms care, including the following:

- If we ask five staff members, they use the same explanation for WHY your site does the 4Ms work.
- If we ask five staff members, they use the same explanation for HOW your site does the 4Ms work.
- Staff at your site will have documentation for the 4Ms work; they can access your 4Ms Care Description and additional standard supporting operating procedures, flowcharts, and/or checklists.
- Training/orientation introduces new staff to the 4Ms work.
- Job description(s) outline elements of the 4Ms work as appropriate to the role.
- Performance evaluation refers to the 4Ms work.

IHI would also expect to learn about regular observation of 4Ms work by site supervisors and leaders who seek to understand and work with staff to remove barriers to reliable 4Ms care.

Appendix H: Measuring the Impact of 4Ms Age-Friendly Care

We highly recommend that you create and monitor an age-friendly measurement dashboard to understand the impact of your efforts. This can be accomplished in two ways:

1. Segment an existing dashboard by age and monitor performance for older adults (ages 65 years and older); or
2. Focus on a small set of basic outcome measures for older adults.

The tables below lists outcome measures that IHI identified to help health systems understand the impact of 4Ms age-friendly care. These measures are not designed to compare or rank health systems in "age-friendliness." We seek to outline measures that are "good enough" to establish baseline performance and are sensitive to improvements, while paying attention to the feasibility of collecting, analyzing, and acting on the results of these data for health systems with a range of skills and capacity in measurement. See the Age-Friendly Health Systems: Measures Guide for additional details on these measures, as well as suggested process and balancing measures.

Basic Outcome Measures	Hospital Site of Care	Ambulatory/Primary Care Site of Care
30-day all-cause readmission rate	X	
Rate of emergency department (ED) visits		X
Consumer Assessment of Healthcare Providers and Systems (CAHPS) — Select survey questions	HCAHPS	CG-CAHPS
Average length of stay	X	

Advanced Outcome Measures	Hospital Site of Care	Ambulatory/Primary Care Site of Care
Older adults with diagnosis of delirium	X	
Survey of care concordance with What Matters collaboRATE (or similar tool adopted by your site to measure goal concordant care)	X	X

Additional Stratification: Impact of Race and Ethnicity

We recognize the persistence of important differences in treatment and health outcomes associated with race, ethnicity, and other social factors. Health equity requires that health systems stratify key performance measures by these factors to reveal disparities and provoke action to eliminate them. For Age-Friendly Health Systems, we encourage stratifying outcome measures for older adults using the Office of Management and Budget core race and ethnicity factors to identify disparities in patient care and experience.

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Appendix C

NEBRASKA HOSPITALS

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nebraskahospitals.org

Age Friendly 7-month curriculum

Welcome

"Too often older adults are needlessly harmed in health care settings and receive care that is inconsistent with what matters to them"

- AHA, Age-Friendly Health Systems Cohort, Join the Movement, 2019.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidenced-based elements of high-quality care, known as 4Ms to all older adults in your system. When implemented together, the 4Ms represent a broad shift by health systems to focus on the needs of older adults.

- ❖ Age-Friendly Health Systems Movement and the 4Ms Framework are not intended to be a model or program that is layered on top of the care that you currently provide. The 4Ms are a framework to organize the efficient delivery and effective care for the older adult.
- ❖ Age-Friendly Health Systems are designed to close the gap between the evidence-based care that has been proven effective and the reliable practice of that care with every older adult in every interaction within every care setting.
- ❖ Many of the 4M driving factors are likely in place within your organization but are not reliably applied or consistently documented.
- ❖ Begin your Age-Friendly Health System journey by recognizing how the 4M framework is already in practice in your organization. Consider what activities you may be able to stop doing when the 4Ms are reliably implemented.
- ❖ The 4Ms work synergistically and should be integrated together into care for every adult age 65 and older during every hospital stay. This consistency creates a highly-reliable model for the care of older adults.

Age-Friendly AIM Statement

- ✓ National Aim - Spread the 4Ms Framework to 20% of US hospitals and Medical Practices by December 31, 2021. This is 1000 hospitals & 1000 primary care Practices.
- ✓ Nebraska Aim – 20% of Nebraska Health Systems will be designated Age-Friendly by 2021.

AHA Action Community Activities

Required Monthly Meetings			
Onboarding (choose one)	September 16 or September 21	11-12pm Central Time	Use link in Getting Started Guide
AHA Team Webinar 1	October 5	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	October 5	12pm – 1pm CT	Passcode: 007964
https://us02web.zoom.us/j/89343129491?pwd=NTVNYzZ6TDdyZW5mUW5qcmdET3dyUT09			
AHA Team Webinar 2	November 2	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	November 2	12pm – 1pm CT	Passcode: 586293
https://us02web.zoom.us/j/87131336850?pwd=QjFFTjJ1Wm9ERmhTakl1REtLY2hEZz09			
AHA Team Webinar 3	December 2	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	December 2	12pm – 1pm CT	Passcode: 414070
https://us02web.zoom.us/j/81253829964?pwd=a2F1aFlDOVJORzhjNjUwekg4L3FpUT09			
AHA Team Webinar 4	January 6	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	January 6	12pm – 1pm CT	Passcode: 747855
https://us02web.zoom.us/j/87025657751?pwd=SG9mekY2NUhhV2VNRDhLOFdrbHBaZz09			
AHA Team Webinar	February - No phone call		
NHA State Discussion	February – No phone call		
AHA Team Webinar 5	March 1	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	March 1	12pm – 1pm CT	Passcode: 467989
https://us02web.zoom.us/j/83329352810?pwd=MmF6ZGlvSmovTFFDbHhUM0tzZUJUUT09			
AHA Final Webinar	April 5	11am – 12pm CT	Use link in Getting Started Guide
NHA State Discussion	April 5	12pm – 1pm CT	Passcode: 108563
https://us02web.zoom.us/j/83947453365?pwd=WkpacERlaFhhbnROVmlxQkp4YUNpZz09			

AHA Action Community Activities	
Monthly Team Webinars (required)	- Team Webinars are 60-minute webinars focused on understanding the steps to implementing Age-Friendly care in your setting and illustrating 4Ms care in action through examples. - Purpose: Teams can define how the 4Ms will be adapted and implemented in their setting and count the number of older adults whose care includes the 4Ms. - Nebraska calls will be hosted immediately following.
Monthly Topical Peer Coaching Webinars (optional open office hours)	- Topical Peer Coaching Webinars provide an opportunity for participants to learn from one another and share ideas, successes and challenges related to a specific topic or setting (e.g., optimizing the EHR, developing measurement systems, ACE units). Occasionally, Topical Peer Coaching calls will be facilitated by expert faculty.

	- Purpose: Through peer sharing, teams identify specific ideas they can test and ways to address challenges.
Monthly Leaders and Sponsors Webinar (leaders)	- Leaders and Sponsors Webinars are designed to support leaders to set up local conditions for scale-up of Age-Friendly Health Systems. Topics will guide you in how to make the case for Age-Friendly care within your organization, including how to make the business case. - Purpose: Leaders have tools and approaches to scale up the 4Ms
Ongoing Testing of Age-Friendly Interventions (required)	- Informed by the Monthly Team Webinars and guided by Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults, participants will test and begin to implement specific key actions in their setting.
Recognition as an Age-Friendly Health System (recognition)	To be recognized as an Age-Friendly Health System, there are two steps: 1. Determine how you will practice the 4Ms in your clinical care setting and submit your description to IHI. 2. Count the number of older adults that receive 4Ms care in your setting and submit that number to IHI. After your description is reviewed and your counts have been shared for at least three consecutive months, you will be recognized as an Age-Friendly Health System and received the Age-Friendly Health Systems participant logo and Media Kit to build local recognition of your work.

** There will be an optional national in-person meeting (date and location TBA pending COVID)

AF Team Recommendations

- Designate an administrative partner (key contact) who represents the disciplines involved in the 4Ms
- Include an older adult and caregiver as core members of the team
- Recognize a leader/sponsor who can authorize and support team activities, engage senior leaders and other parts of the organization to remove barriers and support implementation as needed, and participate in the Action Community leadership track webinars to support scale-up
- Incorporate clinicians who represent the disciplines involved in the 4Ms (possibly including a physician, nurse, physical therapist, social worker, pharmacist, and/or others that represent the 4Ms in your context)
- Include a data analyst/EHR analyst and a finance representative

Recognition:

1. **Level 1** – An **Age-Friendly Health System Participant** is recognized for being on the journey to becoming an Age-Friendly Health System and has submitted a description of how it is putting the 4Ms into practice.

   To be recognized as a Level 1, complete the 4M's Description Survey. IHI will then send you a Participant Badge and a communications kit so you can celebrate this recognition in your local community. IHI may recognized your system's achievement on our website and via media releases

2. **Level 2** – An **Age-Friendly Health System Committed to Care Excellence** is a recognition for being an exemplar in the movement based on 4Ms work that is aligned with

the Age-Friendly System Guide to Using the 4Ms in the Care of the Older Adults and at least three months of data recognizing the care of older adults reached with evidence-based, 4Ms care.

a. Upon completion, IHI will then send you a Committed to Care Excellence Badge and a communications kit so you can celebrate this recognition with your local community. IHI may recognize your system's achievement on our website and via media releases. As an exemplar in the movement, IHI and partners may invite you to share your story and support other health systems.

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- **Getting Started Guide
- **IHI Age-Friendly Guide to Using the 4Ms in the Care of Older Adults:
  - http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf
- IHI What is Age-Friendly Health System
  - http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx
- IHI Toolkit "What Matters to Older Adults"
  - http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf
- The Business Case for Becoming Age-Friendly:
  - http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Business_Case_for_Becoming_Age_Friendly_Health_System.pdf

** Indicates the 2 essential tools hospitals and clinics will need to reference for this program

Assessing and Acting on the 4Ms as a set	Month #1
❖ Understand your current state, select a care setting to begin, set up your team. ❖ Describe what it means to provide care consistent with the 4Ms and set an AIM	

October 5, 2021 12-1pm CT (immediately after AF national Call)

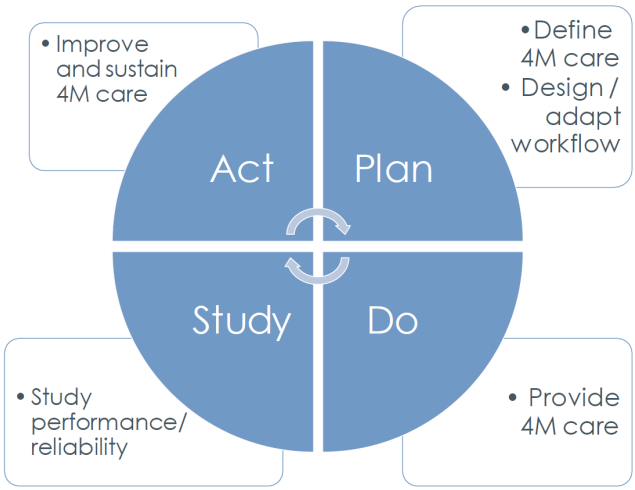
NHA Zoom Discussion:

**Reference the IHI Age-Friendly Health Systems: Guide to Using the 4M's in the Care of Older Adults

Who is on your team and why?	AF Team Recommendations • An administrative partner (key contact) who represents the disciplines involved in the 4Ms • An older adult and caregiver as core members of the team • Leader/sponsor who can authorize and support team activities, engage senior leaders and other parts of the organization to remove barriers and support implementation as needed, and participate in the Action Community leadership track webinars to support scale-up • Clinicians who represent the disciplines involved in the 4Ms (possibly including a physician, nurse, physical therapist, social worker, pharmacist, and/or others that represent the 4Ms in your context) • A data analyst/EHR analyst • A finance representative
How are you identifying your older adult partners?	
How would you describe your current system?	Do you have reliable processes? Every time? What are your gaps?
What is your AIM Statement?	
How do you plan to integrate the 4Ms together?	Describe what it means to provide care consistent with the 4Ms and set an aim • Know how others have put the 4Ms into practice • Know what others have been able to STOP doing
How are you going to collect data? How are you capturing all data points every time?	

Action Steps

Review your 4Ms definition with your team	Ask your team two open-ended questions and reflect on the answers: - What are we doing well to assess and act on the 4Ms? - What do we need to change to translate the 4Ms into more effective care?
Ask at least one older adult and family caregiver two open-ended questions and reflect on the answers:	- What went well in your care today? - What could we do better to understand what Age-Friendly care means to you?



Recipe:

1. Understand your current state
2. Describe what it means to provide care consistent with the 4Ms
3. Design/adapt your workflow to deliver care consistent with the 4Ms
4. Provide care consistent with the 4Ms
5. Study your performance
3. 6.Improve and sustain care consistent with the 4Ms

Setting an AIM

- An AIM statement articulates what you are trying to accomplish. It serves as the focus for your team's work and enables you to measure progress.

  By [April 30, 2021], [NAME OF ORGANIZATION] will articulate how it operationalizes 4Ms care and will have provided that 4Ms care to [NUMBER] patients 65+ years old.

- This statement must be completed and submitted to https://www.surveymonkey.com/r/Z2SGZNJ.

  - Recommendation that AIM statement is also sent to Margaret at the NHA mwoeppel@nebraskahospitals.org

- AIM Statement due on November 2, 2021 to https://www.surveymonkey.com/r/Z2SGZNJ

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- IHI Process Walk-Through
  - https://www.nebraskahospitals.org/quality_and_safety/age-friendly/getting-started.html
- Setting an AIM statement
  - https://www.nebraskahospitals.org/quality_and_safety/age-friendly/getting-started.html
- AHA Website
  - aha.org/AgeFriendly
- Age-Friendly Description worksheet – Hospital
  - https://forms.ihi.org/hubfs/4Ms%20Care%20Description%20Worksheet_Hospital%20and%20Post%20Acute%20May2020.pdf
- Age-Friendly Description worksheet – Ambulatory
  - https://forms.ihi.org/hubfs/4Ms%20Care%20Description%20Worksheet_Ambulatory%20May2020.pdf

AHA email: ahaactioncommunity@aha.org

Assignment:

- By the 5th of each month, please have one key contact from your team complete the survey with:
  - First submission (November 2nd)
  - Your team's Definition of 4Ms Care (AIM statement)
  - IHI recommends that you save your 4Ms Definition Worksheet to reference each month.
- Each month going forward (December 2nd onward)
  - If your definition has changed
  - Number of older adults who have received your definition of 4Ms Care
  - Learnings/questions/challenges from the past month
  - NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org
- Read IHI "What Matters" to Older Adults Toolkit for November discussion
- Bring information and resources in "What Matters" to November discussion

4Ms Deep Dive: What Matters	Month #2
❖ Know and align care with each older adult's specific health outcome goals and care preferences, including but not limited to, end-of-life care, and across settings of care.	

November 2, 2021 12-1 CT (immediately after AF national Call)

Ambulatory	Hospital
Assess • Ask What Matters • Document What Matters	Assess • Ask What Matters • Document What Matters
Act On • Align care plan with What Matters	Act On • Align care plan with What Matters

NHA Zoom Discussion: What Matters

**Reference the IHI Age-Friendly Health Systems:
Guide to Using the 4M's in the Care of Older Adults
"What Matters" to Older Adults Toolkit

What is the message you are sharing with you care team related to "Why you are asking?"	For older adults –Vary in What Matters most –Feel more engaged, listened to –Avoid unwanted care & receive wanted care For health systems –Better patient experience scores & retention –Avoid unnecessary utilization For everyone (patients, caregivers, providers, health system) –Everyone on same page –Improved relationships –It is the basis of everything else
What is your current system?	What are your strengths and gaps Is your process reliable/every time?
How are you asking the older adult what matters most?	Purpose: General getting to know person & what's important –Agree on what information is important –Feasible (time, training, format, method for sharing information) Purpose: Inform care decisions –Feasible (time, training, format, method for sharing information) –Reliable, specific, actionable

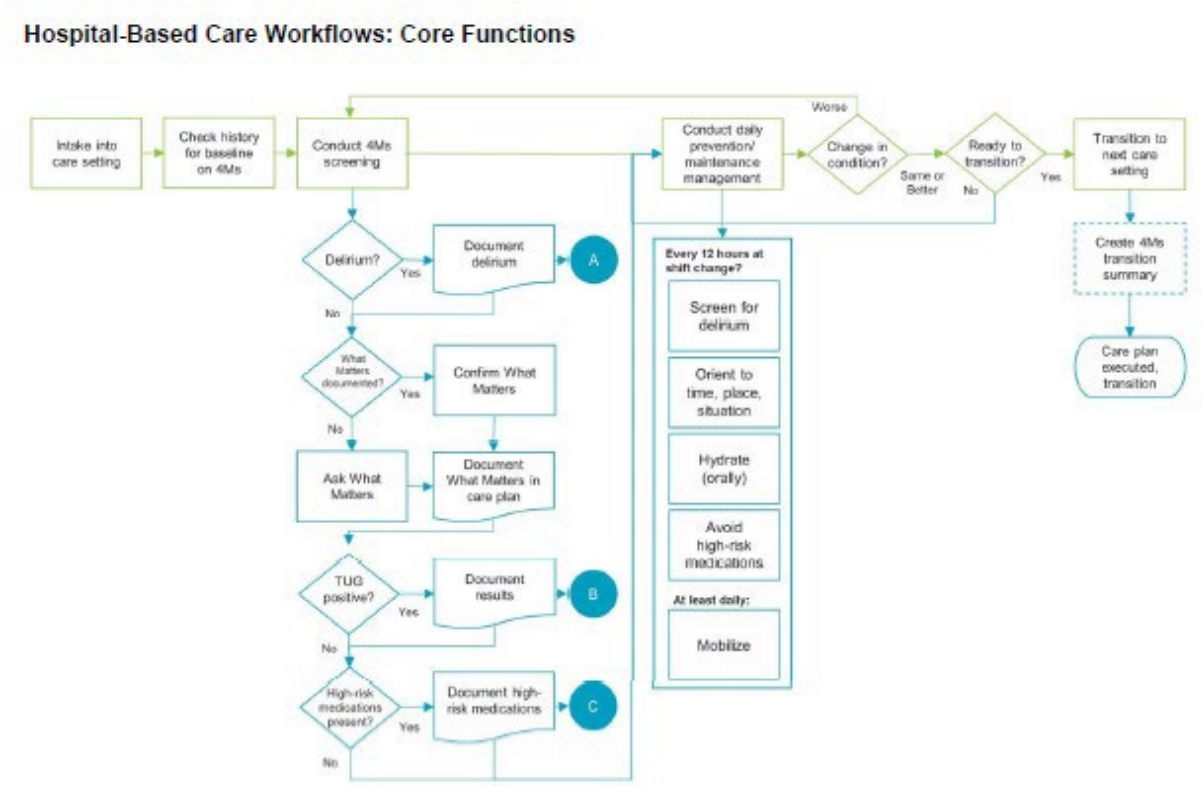
	–Depends on setting & patient population Setting: Immediate decision (e.g. hospital, ED) or ongoing care (e.g., 1º care, ambulatory) –Population: People with chronic conditions or serious illness and/or end of life
How are you documenting this?	
How are you acting on this?	Who has permission to carry this out? How does every care team member know and respond to this? Whose responsibility does this become? How do they know that? How is their performance/follow up assessed?
How do you refuse a patient?	How do you train on this?
How are you aligning your care plan with What Matters most?	
How are you including external persons in this question?	Family? Religious/Chaplain? Community Health Worker Hospital Social Worker - Goal Setting - Family Care Planning Meetings - Additional referrals as needed - Additional tracked data could include: Improved caregiver anxiety, improved self-efficacy, improved depression
What points in the IHI "What Matters" toolkit most struck you as a need in your care setting?	

Process

1. Small-scale tests of change (start with one patient)
2. Design and/or adapt your workflow to deliver care consistent with the 4Ms. Create or edit process flow diagram of your daily care to include Age-Friendly care.
   Provide care consistent with the 4Ms
   Study your performance
   Use the 4Ms to organize care and focus on the older adult strengths rather than solely on disease.

Integrate the 4Ms into care or existing workflows

3. Identify what activities you can stop doing to reallocate resources for the 4Ms and when the 4Ms are reliably in practice.
4. Document all 4Ms and consider grouping the 4Ms together in the medical record. Make the 4Ms visible across the care team and settings
5. Have an interdisciplinary care team that reviews the 4Ms in daily huddles and/or rounds.
6. Educate older adults, caregivers, and the community about the 4Ms.
7. Link the 4Ms to community resources and supports to achieve improved health outcomes.
8. Now PDSA



**Be specific about who will do what, where, when, how, and how it will be documented. Outline what you still need to learn and what you will test.

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- IHI Toolkit “What Matters” to Older Adults?
  - http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf
- IHI’s Conversations On End of Life – white paper
  - http://www.ihi.org/resources/Pages/IHIWhitePapers/ConversationReadyEndofLifeCare.aspx

Assignment:

By the 5th of each month, please have one key contact from your team complete the survey with: (December 5th onward)

- If your definition has changed
- Number of older adults who have received your definition of 4Ms Care
- Learnings/questions/challenges from the past month
- NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org

- Develop/modify your care setting AF workflow

4Ms Deep Dive: Medication	Month #3
❖ If a Medication is necessary, use an Age-Friendly medication that does not interfere with What Matters to the Older Adult, Mobility, or mentation across the settings of care.	

December 2, 2021 12-1 CT (immediately after AF national Call)

Ambulatory	Hospital
Assess • Review high-risk medication use	Assess • Review high-risk medication use
Act On • Deprescribe or do not prescribe high-risk medication	Act On • Deprescribe or do not prescribe high-risk medication

NHA Zoom Discussion: Medication

**Reference the IHI Age-Friendly Health Systems: Guide to Using the 4M's in the Care of Older Adults

Who is the champion of this M?	
How will you review high risk medications?	Identify for Potentially inappropriate medications for older adults include the following: • Benzodiazepines • Opioids • Highly-anticholinergic medications (e.g., diphenhydramine) • All prescription and over-the-counter sedatives and sleep medications • Muscle relaxants • Tricyclic antidepressants • Antipsychotics How do you assess patients taking more than one high-risk or incompatible medication?
How do you review high risk medications for the older adult consistently (every time)?	Is Pharmacist involved?
How do you assess for adverse reactions to medication?	How many adverse reactions do you catch?
How are you avoiding/Adjusting/Unprescribing high-risk medications?	How are you having these conversations with physician? How do you handle a reluctant provider?

How do you involve patients/family in education and determination of medications?	What are they using? How does this impact their health? Why should they take one medication vs another? How do you discuss deprescribing to patient?
How do you involve patients/family in medication compliance?	Why important to take medication as directed? How do you handle patient concerns: Cost of medication, access to medications? Other concerns? Include a medication list printout as part of standard check-out steps and ensure that the older adult and family caregivers understand: • What their medications are for • How to take them • Why they are taking them • How to monitor whether they are helping or possibly causing adverse effects.
What non-pharmacologic sleep or pain options do you use?	
Do you use a fall prevention tool that considers medication in the evaluation?	Examples of Fall Prevention Tools that include medication evaluation • Hester Davis Fall Program • John Hopkins Falls risk assessment • Morse Fall Assessment, and then added points for Sedatives/Narcotics/Analgesics/Hypnotics, Diuretics/Laxatives, and Anticoagulants • CDC STEADI program

High Risk Medication:

- Benzodiazepines – There has been a great deal of research and data stating that benzodiazepines class medications are associated with increased risk of dementia, delirium, falls, and there is implication on motor vehicle accidents as well. So we would need to access how we are prescribing them, and then challenging ourselves to deprescribe them or find another safe alternative.
- Opioids – And then if you are prescribing benzodiazepines class medication with opioids, that creates a greater risk. So think how once class of medication, in combination with another can increase risks of negative outcomes for older adults.
- Highly-anticholinergic medications (e.g., diphenhydramine) – Highly anticholinergic medications cross over other types of medications as well, such as oxybutynin. And recently there has been evidence around highly-anticholinergic medications and risk of dementia.
- And then the same applies for all prescription and over-the-counter sedatives and sleep medications, muscle relaxants and tricyclic antidepressants. A recent white paper from the American Geriatrics Society highlights some alternative medications that are safer, in

addition to some non-medication approaches hospitals can take to provide age-friendly care and reduce the risks that come with these types of medications.

- Antipsychotics - And then increasing our attention to antipsychotics and why we are using antipsychotics and its impact on dementia in older adults
    - American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults Access at: https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15767

Beers Criteria

- Benzodiazepines
- Opioids
- Highly anticholinergic medications
- Diphenhydramine (Benadryl)
- OTC sleep agents
- Sedatives
- Muscle relaxers
- Tricyclic antidepressants
- Early generation antipsychotics

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- Tools and Support
    - “Potentially Inappropriate Medications in Older Adults According to Beers List and STOPP Criteria” Tool by TMF QIN
    - Yale Medicine Medication Workflow Diagram
- White Papers
    - “American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults” The American Geriatrics Society
    - “The 2019 American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults” The Hartford Institute for Geriatric Nursing
    - “Safely Reducing the Number of Medications, You Take” Methodist Health System
    - “Alternative Medications for Medications in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug-Disease Interactions in the Elderly Quality Measures” The American Geriatrics Society
- Other Medication Resources
    - “Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines” IHI Publications
    - Health information for Older Adults and their Caregivers at healthinaging.org
    - Alternatives for Medications Listed in the AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults at healthinaging.org
    - Crosswalk: Evidence-Based Leadership Council Programs & the 4Ms
    - Deprescribing.org

Assignment:

By the 5th of each month, please have one key contact from your team complete the survey with: (December 5th onward)

- If your definition has changed
- Number of older adults who have received your definition of 4Ms Care
- Learnings/questions/challenges from the past month
- NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org

4Ms Deep Dive: Mentation	Month #4
❖ Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.	

January 6, 2022 12-1pm CT (immediately after AF national Call)

Ambulatory	Hospital
Assess • Screen for dementia • Screen for depression	Assess • Screen for delirium at least every 12 hours
Act On • Consider further evaluation and manage manifestations of dementia, or refer • Identify and manage factors contributing to depression	Act On • Orient older adults to time, place and situation • Ensure older adults have their personal sensory adaptive equipment • Prevent sleep interruptions, use non-pharmacological interventions to support sleep

NHA Zoom Discussion: Mentation

**Reference the IHI Age-Friendly Health Systems: Guide to Using the 4M's in the Care of Older Adults

Who is the champion of this M?	
Are you screening for delirium?	Tool? Admission? Every 12 hours? Delirium has an underlying cause and is preventable and treatable in most cases. Care teams need to: 1. Remove or treat underlying cause(s) if it occurs 2. Restore or maintain function and mobility 3. Understand delirium behaviors 4. Prevent delirium complications Clinic wellness visits? How are staff maintaining competency on this?
Do you have a delirium prevention & management protocol?	Does this include patient orientation? How is staff educated on this? How would staff respond to a sudden change in patients' cognitive level? Would they recognize?
How are you assessing mentation per shift?	Where/how is this assessed?
How do you assess for/ rule our delirium caused dementia?	

How do you educate families and care givers on signs of delirium?	What does the caregiver do if they notice this?
How do you ID delirium	Staff training on recognition
How do you ensure sufficient oral hydration and nutrition?	
How do you orient older adults to time, place and situation?	White boards Large faces accurate clock All About Me board Orient per visit, shift
How do you ensure patients have their personal sensory adaptive equipment?	In hospital? Afford at home? Batteries?
How do you support non-pharmacological sleep?	
How do you prevent sleep interruption?	Blood draws at 6am instead of 4am Allow inpatient to continue at home sleep schedule (i.e. stay up late and sleep in)
How do you screen for depression?	

Measure your impact

Basic Outcome Measures	Hospital Setting	Ambulatory/Primary Care Setting
30-day readmissions	X	
Emergency department utilization		X
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions	HCAHPS	CGCAHPS
Length of stay	X	

Advanced Outcome Measures	Hospital Setting	Ambulatory/Primary Care Setting
Delirium	X	N/A
collaboRATE (or similar tool adopted by your site to measure goal concordant care)	X	X

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- Tools and Support
  - Confusion Assessment Method (CAM) Tool
  - Nursing Delirium Screening Scale (NuDESC)
- White Papers
  - "The Geriatric Depression Scale" The Hartford Institute for Geriatric Nursing
  - "Assessing and Managing Delirium in Older Adults with Dementia" The Hartford Institute for Geriatric Nursing
  - "The Confusion Assessment Method for the ICU (CAM-ICU)" The Hartford Institute for Geriatric Nursing
  - "Mental Status Assessment of Older Adults: The Mini-Cog" The Hartford Institute for Geriatric Nursing
  - "The Confusion Assessment Method (CAM)" The Hartford Institute for Geriatric Nursing White Paper
  - "Providing Delirium Prevention in Age-Friendly Care" Catholic Health Association of the United States
- Other Mentation Resources
  - The International Federation of Delirium Societies
  - Hospital Elder Life Program (HELP) for Prevention of Delirium
  - Oxford Medical Education CAM website
- Dementia in the Emergency Department
  - The Geriatric Emergency Department Collaborative

- Emergency Department Care of Individuals who have Dementia: An Implementation Toolkit

Assignment:

By the 5th of each month, please have one key contact from your team complete the survey with: (December 5th onward)

- If your definition has changed
- Number of older adults who have received your definition of 4Ms Care
- Learnings/questions/challenges from the past month
- NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org

- What impact can you measure?

4Ms Deep Dive: Mobility	Month #5
❖ Ensure older adults move safely every day in order to maintain function and do what matters.	

March 1, 2021 12-1pm CT (immediately after AF national Call)

Ambulatory	Hospital
Assess • Screen for mobility	Assess • Screen for mobility
Act On • Ensure safe mobility	Act On • Ensure early and safe mobility

NHA Zoom Discussion: Mobility

**Reference the IHI Age-Friendly Health Systems: Guide to Using the 4M's in the Care of Older Adults

Who is the champion of this M?	
How do you screen for mobility?	Who does this upon admission? How often are you screening/assessing? Mobility assessment can be part of the Medicare annual wellness plan. Older adults may be self-conscious about mobility issues or fear out of home placement. What are goals of patient/family in mobility?
What functional assessment do you use?	Has this been validated in your facility?
How do you document mobility screen	How do you assess mobility has happened every day? How do you assess mobility changes are being recognized shift to shift.
How do you ensure early and safe mobility?	In hospital? At home?
Can you access physical therapy as needed?	Physical therapy to help with balance, gait, strength, training, or exercise program if needed PT can assess and managing mobility impairments
Do you have a Falls risk assessment?	How often is this assessed? Which Falls risk assessment is being used? Has this Falls risk assessment been validated? Does your tool consider medications in the evaluation?
How do you manage bowl/bladder problems in mobility care plan?	

How early after a procedure or surgery does your policy determine you mobilize patient?	
How often are you mobilizing patient per day/shift?	Goals • Ambulate at least three times a day. • Set, monitor, and meet daily mobility goals. • Out of bed or room for meals.
Do your policies call for bedrest? Should they?	Many organizations not allowing bedrest orders to be entered.

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- Tools and Support
  - University of Nebraska Medical Center CAPTURE Falls
- White Papers
  - "The Lawton Instrumental Activities of Daily Living (IADL) Scale" The Hartford Institute for Geriatric Nursing
  - "Reducing Functional Decline in Older Adults during Hospitalization: A Best Practice Approach" The Hartford Institute for Geriatric Nursing
  - "Katz Index of Independence in Activities of Daily Living (ADL) The Hartford Institute for Geriatric Nursing
- Mobility in the Emergency Department
  - Management of Older Adult Falls and Mobility in the Emergency Department: An Implementation Toolkit

Assignment:

By the 5th of each month, please have one key contact from your team complete the survey with: (December 5th onward)

- If your definition has changed
- Number of older adults who have received your definition of 4Ms Care
- Learnings/questions/challenges from the past month
- NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org

4Ms Sustain & Scaling Up	Month #6

April 5, 2022 12-1 CT (immediately after AF national Call)

NHA Zoom Discussion: Sustain and Scaling Up

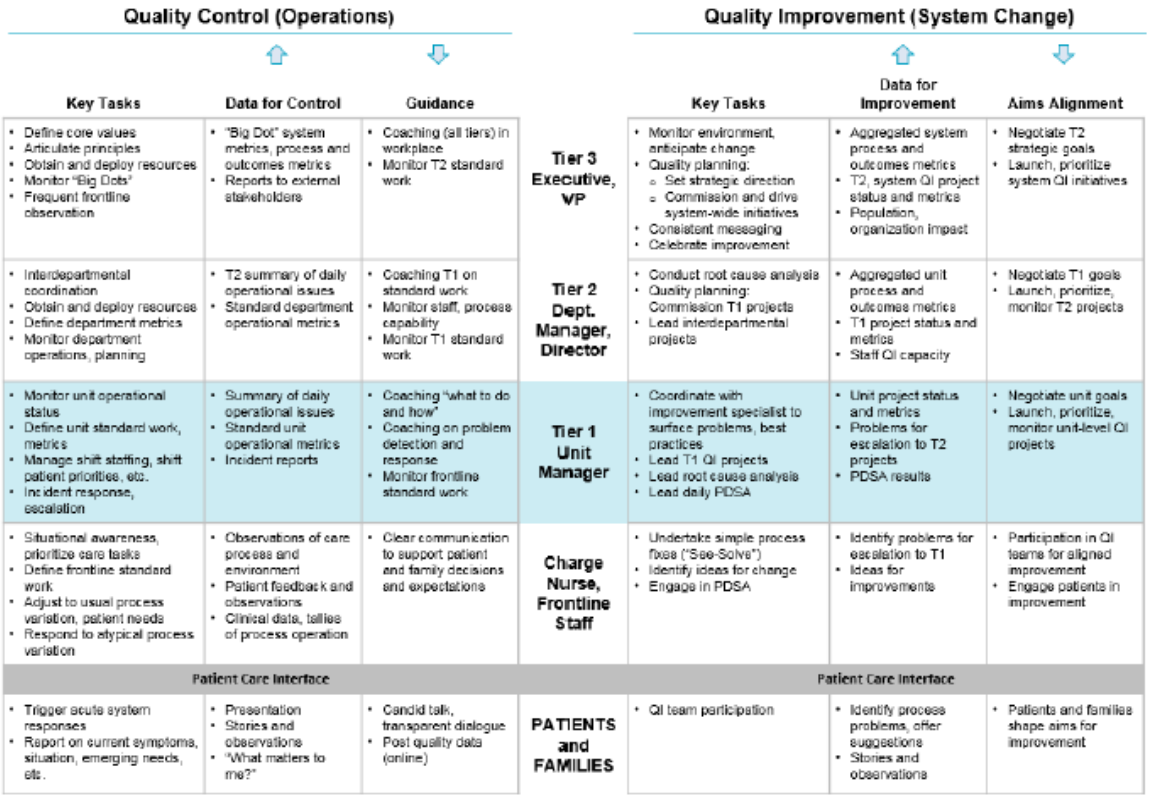
Who is responsible for sustaining change?	How often will the process be assessed?
How do you intend on scaling up?	How will you scale up? Who is responsible for scale up? Are there any barriers to scaling up? Sustaining your improvements for care is a cycle (in which you might cycle through steps multiple times while improving your setting) Scaling up huddles
Are you displaying data?	Use education boards posted in a public hallways of hospital to track data and progress Include in senior leader and board member reports
Are you utilizing available payment models?	CCM? TCM?

Resources:

** All Resources can be found on https://www.nebraskahospitals.org/quality_and_safety/age-friendly/age-friendly.html

- Tools and Support
  - IHI Sustaining Improvement whitepaper

Figure 2. Architecture of a High-Performance Management System



Quality Control (Operations)				Quality Improvement (System Change)		
Key Tasks	Data for Control	Guidance		Key Tasks	Data for Improvement	Aims Alignment

• Define core values
• Articulate principles
• Obtain and deploy resources
• Monitor "Big Dots"
• Frequent frontline observation
	• "Big Dot" system metrics, process and outcomes metrics
	• Reports to external stakeholders
		• Coaching (all tiers) in workplace
		• Monitor T2 standard work
			Tier 3 Executive, VP	• Monitor environment, anticipate change
				• Quality planning:
				  ▫ Set strategic direction
				  ▫ Commission and drive system-wide initiatives
				• Consistent messaging
				• Celebrate improvement
					• Aggregated system process and outcomes metrics
					• T2, system QI project status and metrics
					• Population, organization impact
						• Negotiate T2 strategic goals
						• Launch, prioritize system QI initiatives

• Interdepartmental coordination • Obtain and deploy resources • Define department metrics • Monitor department operations, planning	• T2 summary of daily operational issues • Standard department operational metrics	• Coaching T1 on standard work • Monitor staff, process capability • Monitor T1 standard work	**Tier 2 Dept. Manager, Director**	• Conduct root cause analysis • Quality planning: Commission T1 projects • Lead interdepartmental projects	• Aggregated unit process and outcomes metrics • T1 project status and metrics • Staff QI capacity	• Negotiate T1 goals • Launch, prioritize, monitor T2 projects
• Monitor unit operational status • Define unit standard work, metrics • Manage shift staffing, shift patient priorities, etc. • Incident response, escalation	• Summary of daily operational issues • Standard unit operational metrics • Incident reports	• Coaching "what to do and how" • Coaching on problem detection and response • Monitor frontline standard work	**Tier 1 Unit Manager**	• Coordinate with improvement specialist to surface problems, best practices • Lead T1 QI projects • Lead root cause analysis • Lead daily PDSA	• Unit project status and metrics • Problems for escalation to T2 projects • PDSA results	• Negotiate unit goals • Launch, prioritize, monitor unit-level QI projects
• Situational awareness, prioritize care tasks • Define frontline standard work • Adjust to usual process variation, patient needs • Respond to atypical process variation	• Observations of care process and environment • Patient feedback and observations • Clinical data, tallies of process operation	• Clear communication to support patient and family decisions and expectations	**Charge Nurse, Frontline Staff**	• Undertake simple process fixes ("See-Solve") • Identify ideas for change • Engage in PDSA	• Identify problems for escalation to T1 • Ideas for improvements	• Participation in QI teams for aligned improvement • Engage patients in improvement
Patient Care Interface				Patient Care Interface		
• Trigger acute system responses • Report on current symptoms, situation, emerging needs, etc.	• Presentation • Stories and observations • "What matters to me?"	• Candid talk, transparent dialogue • Post quality data (online)	**PATIENTS and FAMILIES**	• QI team participation	• Identify process problems, offer suggestions • Stories and observations	• Patients and families shape aims for improvement

Process

1. The creation of standard work is vital for sustaining improvements. Standard work is required of managers at all levels (Tiers 1, 2, and 3), referred to as “management standard work” (MSW).
2. Different types of MSW are needed for all the Tiers:
3. Tier 1 leaders are responsible for identifying unit-level process measures, collecting the required data, and maintaining visuals for huddles
4. Tier 2 and Tier 3 leaders determine the measures needed to monitor the standard work system and are responsible for acquiring the needed data (via huddles and direct observation, and with the help of improvement specialists).
5. Spreading changes and sustaining performance improvement requires Tier 1 and Tier 2 managers to practice their own standard work, including coordination with other departments or service lines

Assignment:

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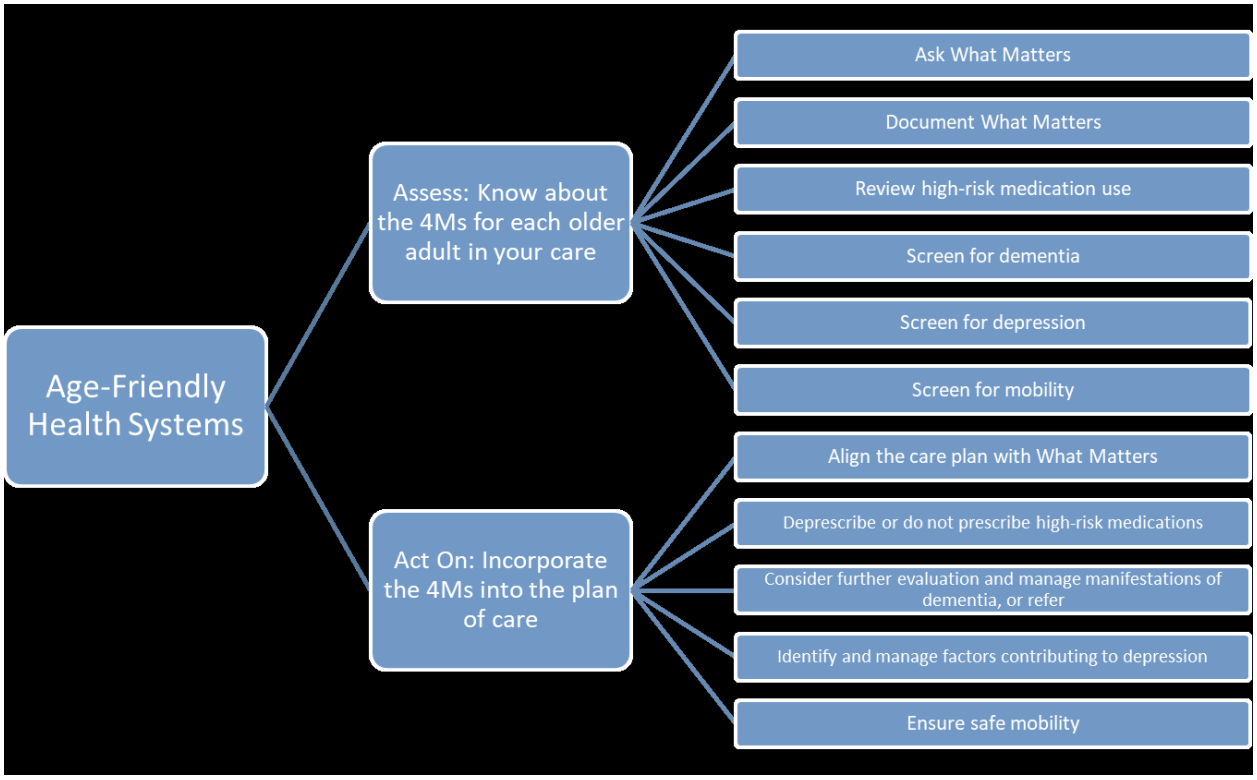
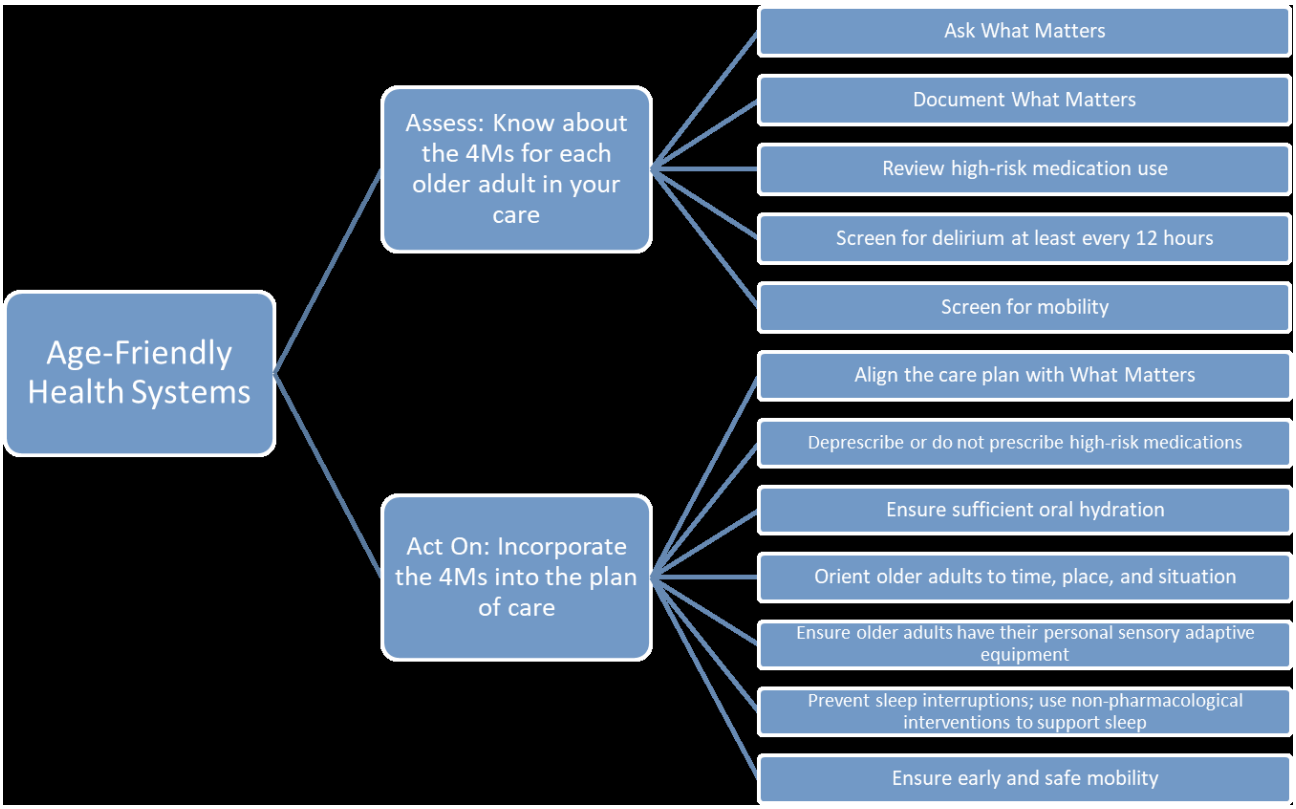
- If your definition has changed

- Number of older adults who have received your definition of 4Ms Care
- Learnings/questions/challenges from the past month
- NHA recommends hospitals/clinics cc Margaret on emails to IHI mwoeppel@nebraskahospitals.org
- **Remember that in order to maintain Age-Friendly recognition Level 2, 3 months of data must be summited to IHI annually.

Ambulatory



Hospital



Appendix D

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).

Dear Leader,

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), set a bold vision to build a social movement so that all care with older adults is age-friendly care. According to their definition, age-friendly care:

- Follows an essential set of evidence-based practices;
- Causes no harm; and
- Aligns with What Matters to the older adult and their family or other caregivers.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms" (What **M**atters, **M**edication, **M**entation, and **M**obility) to all older adults in your system. When implemented together, the 4Ms represent a broad shift by health systems to focus on the needs of older adults.

An Age-Friendly Health System has a focus on:

- Better health outcomes for older adults;
- Reduced waste associated with low-quality services;
- Increased utilization of cost-effective services for older adults; and
- Improved reputation and market share with a rapidly growing population of older adults.

A team from your system has requested to participate in a seven-month Action Community, facilitated by IHI, to accelerate the work of becoming an Age-Friendly Health System. Care locations, including hospitals, practices, nursing homes, and convenient-care clinics, can be recognized by IHI and The John A. Hartford Foundation for their commitment to practice age-friendly care. To date, over 1,000 care locations have received this recognition. The cost of recognition and participation in an Action Community is underwritten by The John A. Hartford Foundation.

During the Action Community, our team will:

- Choose a care setting to pilot test the 4Ms in our health system;
- Identify and build on what our health system is already doing well across the 4Ms and create a plan, known as a our 4Ms Care Description, for how we will practice 4Ms together as a set;
- Test and learn about how our care setting can locally adapt the 4Ms based on our unique conditions; and
- Learn, and apply, tactics to sustain age-friendly care and scale-up to other units or care locations in our system including adapting our EHR, understanding the business case for age-friendly care in our system, and learning from stories and data of impact on older adults and caregivers.

The data submission required to participate in this Action Community is minimal. We agree to:

- Submit a 4Ms Care Description, which is a plan for how we will assess and act on all 4Ms as a set;
- Submit a count of the number of older adults receiving 4Ms care for at least three months. While we are still testing, IHI knows that this number might be small.
    - Stratify the count of the number of older adults receiving 4Ms care by race and ethnicity. This is optional, but highly encouraged by IHI to ensure we are using data to know whether all older adults have equitable access to high quality, 4Ms care.

Throughout 2022 there will be opportunities for you to engage with leaders from other health systems adopting the 4Ms to learn how they using the 4Ms to advance their system's strategic priorities.

As a key leader in your organization, we thank you for the support of your system's goal of making care safer and more reliable for the older adults in our system.

We know that with your commitment to the team members listed below, you are building a successful age-friendly model of care at your organization for years to come.

I, _____ (name), _____ (title), at

_____ (organization name) commit to supporting the following representatives from my organization in participation in the Age-Friendly Health Systems Action Community.

Leadership Signature _____

Date _____

Team 1: _____ (name of team/unit practice)

_____ (name and title day-to-day Leader/Change Agent)

_____ (name and title of Clinician)

_____ (name and title of Administrative Partner)

_____ (name and title of Designated Reporter)

Team 2: _____ (name of team/unit practice)

_____ (name and title day-to-day Leader/Change Agent)

_____ (name and title of Clinician)

_____ (name and title of Administrative Partner)

_____ (other)

Team 3: _____ (name of team/unit practice)

_____ (name and title day-to-day Leader/Change Agent)

_____ (name and title of Clinician)

_____ (name and title of Administrative Partner)

_____ (other)

Team 4: _____ (name of team/unit practice)

_____ (name and title day-to-day Leader/Change Agent)

_____ (name and title of Clinician)

_____ (name and title of Administrative Partner)

_____ (other)

Please copy or delete Team fields to include as many teams as you want to enroll and email the signed letter to AFHS@IHI.ORG.