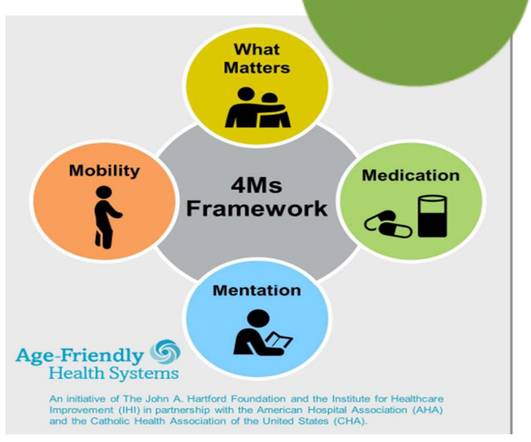
Petaluma Health Center

November 2022



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.

Institute of Healthcare Improvement (IHI) Level 2 Recognition (Committed to Care Excellence)

Redwood Community Health Coalition
Promising Practice

PROMISING PRACTICE OVERVIEW

IHI recognizes clinical care settings working towards the practice commitment of evidence-based interventions for older adults in their care using the 4Ms (What Matters, Medications, Mentation, Mobility). Petaluma Health Center (PHC) started its project in 2021 to organize the care of older adults using evidence-based practices that are consistent with what matters to the patients and their families. They enrolled in the IHI Cohort and attended meetings, and began following patients. The goal is to create a shift of "Care Culture" in older adults, not only by implementing the 4Ms but an approach as to "WHY" this care needs to be done. The Level 2 recognition is a commitment to excellence, not that it has been achieved, only that you are committed. Find the IHI Guide HERE

AIM

The goal is for all providers who care for older adults 65 and older to provide evidence-based care using elements of the 4Ms as the framework and to ensure there is an intervention that follows every action.

MEASURES

Age-Friendly Health System 4Ms Framework
IHI Age-Friendly Health Systems
Level 1 **(Participant)** teams have successfully developed plans to implement the 4Ms, and
Level 2 **(Committed to Care Excellence**) teams have three months of data of older adults who received 4Ms care.

WORKFLOW

4Ms Educational Session → New Clinical Process Based on Session Topic → Implement Template & Workflow

Enroll in the IHI Cohort: Apply for *Level I* and submit your plan of action for *Level 2.* Submit your 4Ms Care Description HERE
Operationalize: Meet frequently with all stakeholders who have an interest in older adult care; create a Task Force.
Education: Critical Step - Set up a series of lectures - UCSF offers a series of lectures on topics around 4Ms – RCHC 4Ms QI Podcasts are also available HERE (search for GWEP).
Implement Care Gaps and Templates | Modules: The modules created a system of care that is more usable and more flexible. These enable you to mine and track data (usage).
Three Care Gaps (Medications, Morbidity, and What Matters)
Five Templates | Modules (4M Medications, 4M Morbidity, 4M What Matters, 4M Mentation, and 4M All). 4Ms templates were developed in eCW, and the 4M All report was designed in Relevant.
Medications Module: Run a report from the EHR to capture patients 65 years of age or older who are on the Beers list or have polypharmacy. A care gap\alert\reminder is built into the module that triggers an intervention and a workflow. The MA uses this to remind the patient to bring their medication, the medication list is printed and reviewed with the Medical Assistant (MA), patient, and provider. The discussion and intervention are documented.
What Matters Module: Ask the patient what matters and document their response in the EHR.
Mentation Module: If a patient does not score well on a mental status assessment tool, the goal is to perform more comprehensive assessments and possibly refer them for dementia management.
Mobility Module: If a patient is at risk for falls or has a mobility impairment, the interventions/action could be referring them to skilled therapy or referring them to a fall-prevention class.
4M All: Tracks Module Usage (the report is extracted from Relevant)

ACTIONS TAKEN

- The plan was to try to address all 4M areas in one 45-minute visit that would tie into the Medicare Annual Wellness Visit.
- An initial PDSA that covered all four aspects of the 4Ms within one encounter quickly proved that the goal was too large. Allotting 45 minutes per encounter was not feasible, especially with the current access challenges.
- Another cycle was run, breaking down the 4Ms into four modules; this was a manageable solution. For each of the 4Ms, a specific template was built within the EHR to address the focus. For instance, the medication template helps direct staff to review any high-risk medications, medications that are on the Beers list, or patients who have polypharmacy with many medications on their list. An alert and reminder were built to identify the patients who need this intervention based on age and if they have a high-risk medication on their list or if they have more than 14 medications on their list. This triggers a workflow for staff to remind patients to bring all their medications to the visit. The medication list is printed and reviewed with both the patient and provider to review or revise if needed. The provider looks at the medications and will document an intervention of what happened in that discussion with an action to follow. A pre-existing system of care gaps and templates is used to identify which patients need the intervention, and then the intervention and action are laid out in the template.
- Using the module approach: We broke it down in this way to make it more achievable for providers and staff to incorporate each of these into a regular visit, allowing for more flexibility. This system allows the provider to use whatever module is appropriate at the time.
- We took a stepwise approach to roll out the modules and did so to be in concert with our education series. UCSF provided an introductory talk and overall introduction to the 4Ms framework, giving staff program background. We then followed up with a medication-focused educational talk (this was an area that we found was the highest risk in our practice.) We ran a report and discovered that 4500 patients over 65 had polypharmacy or were on high-risk medication. The medication module was then launched.
- **Meetings**
  All Provider Meetings: UCSF GWEP 4Ms orientation and educational talks occurred during some of these meetings. After these talks, workflows and processes are reviewed and implemented into patient care.
  Team Meetings with clinicians, MAs, and Nurses. The 4Ms medication template and workflow were rolled out. Report on progress with medical staff.

RESULTS TO DATE

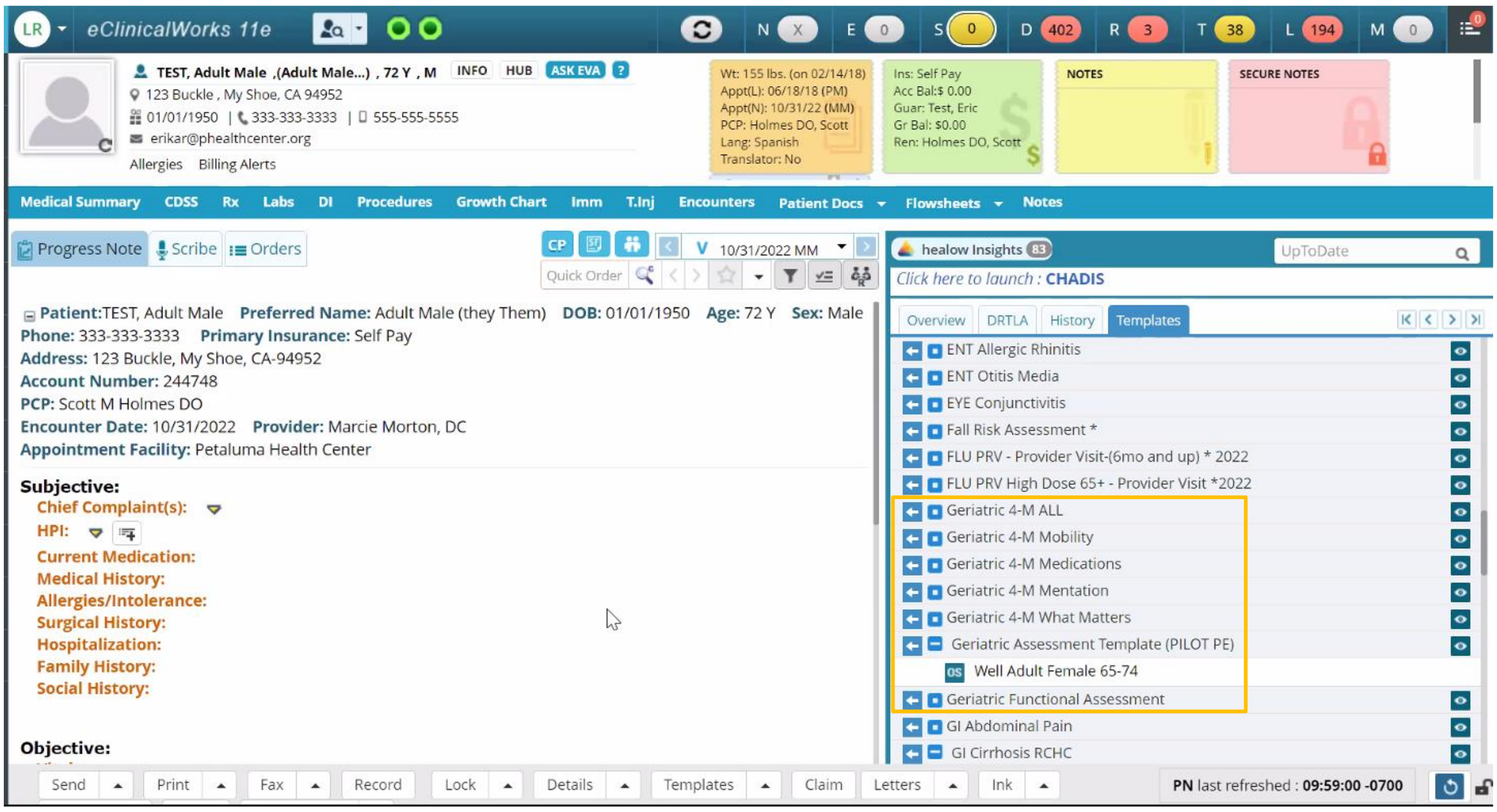
Providers are revising their approach to care for the 65 and older patient population. Using the 4MAll report follows the usage of the modules and shows that providers are using the templates more and more with time. Cognitive screening clear intervention is being developed to measure the outcome results (initial poor screening, referral, and outcome). The developed modules track and monitor use making sure there is an intervention that follows every action.

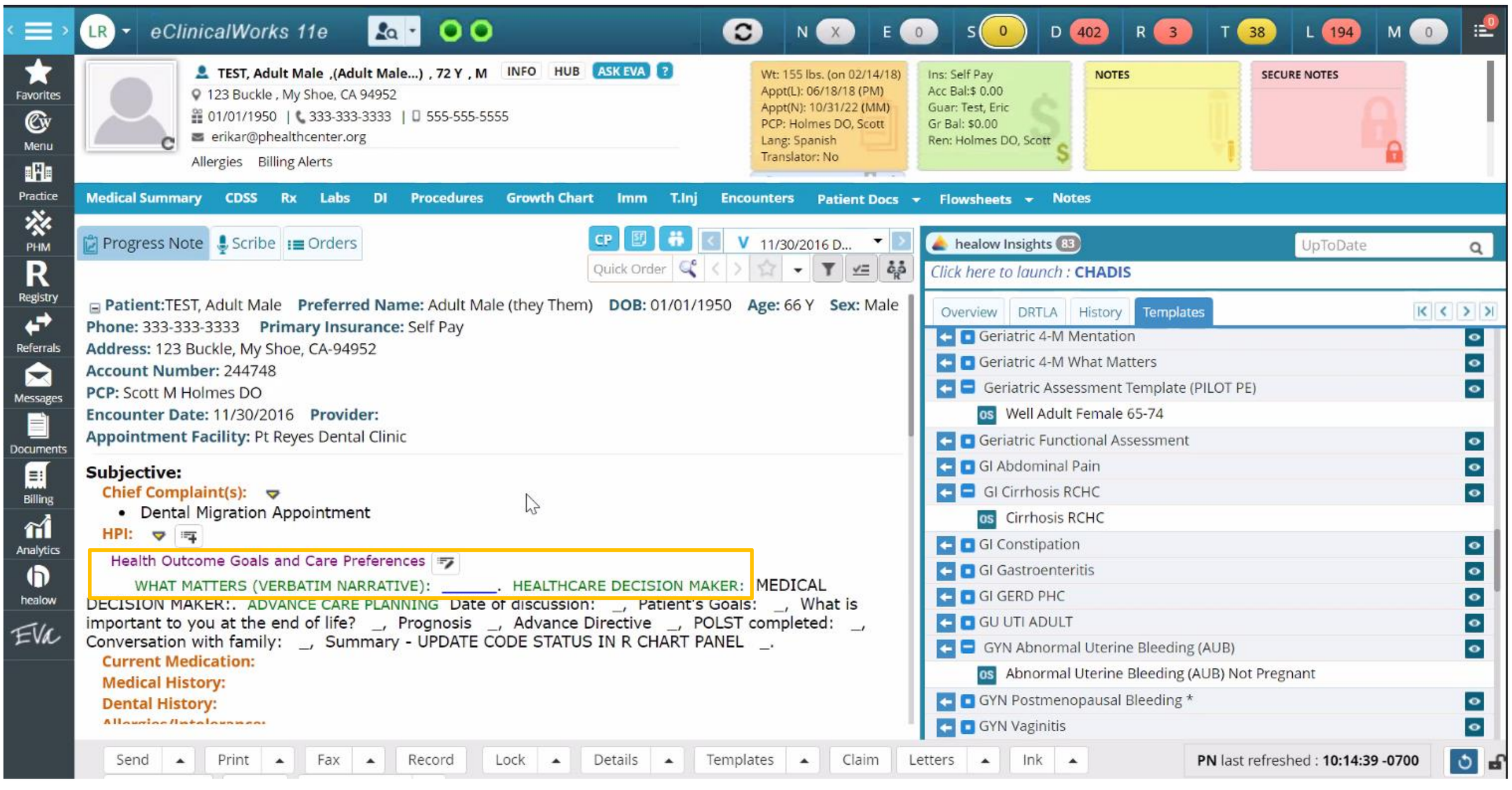
LESSONS LEARNED

Choose a Provider and another support staff to navigate the IHI Cohort so that all meetings can be attended by one or the other. Education is key. PHC implemented an operational approach for the 4Ms measures. "You have to decide what intervention will be patient-supportive." The modular approach allows the 4Ms to be addressed where appropriate and gives care flexibility. The purpose is to have all the 4Ms addressed within the same year and then every year going forward.

Relevant and eClinicalWorks Reports

eCW Test Chart Visuals





Relevant Report Showing Template Use

Report shows how many times the 'Geriatric 4-M ALL' , 'Geriatric 4-M Medications', 'Geriatric 4-M Mobility', 'Geriatric 4-M What Matters' or 'Geriatric 4-M Mentation' template has been used and by what provider.

Run Expected run time: 1.254 sec.

Results | Total Times by Provider | Add view

cyocobalamin standard | cci mortality chart - Goo | Petaluma Health Center | Charlson Comorbidity In | Relevant: Geriatric Templ

phc.relevant.healthcare/report_builder/reports/750

New Tab ACB Calculator Point Click Care SDI Online

template / used_by	Geriatric 4-M Medications	Geriatric 4-M Mentation	Geriatric 4-M What Matters	Geriatric 4-M ALL	Geriatric 4-M Mobility	Totals
Ashcroft MD, Andrew	3			1	5	9
Benenhaley FNP, Leesa	2					2
Chase FNP, Carolyn	21	4		5	6	36
Chen DO, Iun-Iu	1					1
Chi MD, Carlin	11				2	13
Choe MD, Jonathan	5				1	6
Diel FNP, Joanna	5				3	8
Dittrich NP, Heidi	3			1		4
Edouard MD, Philippe	6		1		14	21
Fisher NP, Kimberly	2					2
Gary FNP, Erika					1	1
Gomez MD, Ulysses					2	2
Gomez-Mira MD, Christina	2			4	3	9