CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

RHODE ISLAND DEPARTMENT OF HEALTH

Welcome

Delivering Age-Friendly Care
Implementing the 4M Model and Supporting Care Partners of People with Dementia: A Path to Level 1 or Level 2 Recognition from the Institute for Healthcare Improvement

Kick Off Learning Collaborative

September 10th, 2024

Care Transformation Collaborative of RI

Agenda

ADVANCING INTEGRATED HEALTHCARE

Topic & Presenter	Duration
Welcome, Thank you, and Introductions *Victoria O'Connor*	7:30 – 7:40 AM
Presentation: What does Age-Friendly mean to you? *Jenny Knecht-Fredo*	7:40 - 8:10 AM
Participating Practices: Welcome and Introductions *PACE-RI, Breakwater Primary Care (Dr Yamada and team), Brown Medicine, CNE Family Care Center, University Internal Medicine, Breakwater Primary Care (Dr. Steinmetz and team)*	8:10 - 8:30 AM
Pre-Assessment Results *Suzanne Herzberg*	8:30 - 8:40 AM
Review of Milestone Document and Resource Guide *Christine Ferrone*	8:40 - 8:50 AM
Discussion & Questions *Christine Ferrone*	8:50 - 8:55 AM
Next Steps: Plan for Practice Facilitation *Susanne Campbell*	8:55 – 9:00 AM

Getting to Know Rhode Island Department of Health (RIDOH) & Care Transformation Collaborative RI (CTC-RI)

Victoria O'Connor, MHA, Alzheimer's Disease and Related Disorders Program Manager

RIDOH

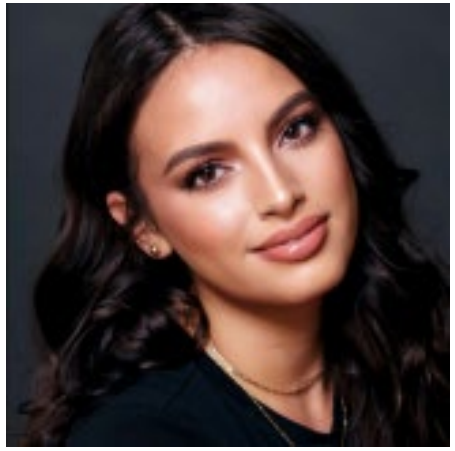
Pano Yeracaris, MD, MPH

Chief Clinical Strategist

CTC- RI

Susanne Campbell, RN, MS, PCMH CCE, Senior Program Administrator

CTC-RI



Nijah Mangual, BA Program Coordinator

CTC-RI

Getting to Know your Practice Facilitators

Suzanne Herzberg, PhD, MS, OTR/L
Practice Facilitator
Clinical Assistant Professor of Family Medicine

Breakwater Primary Care
Dr. Yamada

PACE-RI

Christine Ferrone, MS
Program Manager
RI Geriatric Education Center

Brown Medicine

Care New England Family Care Center

Jayne Daylor, RN MSN
Practice Facilitator, CTC-RI

University Internal Medicine

Breakwater Primary Care
Dr. Steinmetz

Thank You to our Funders

United Healthcare

RHODE ISLAND DEPARTMENT OF HEALTH

RIGEC
Rhode Island Geriatric Education Center

Welcome to our Subject Matter Expert!

PennState Ross and Carol Nese College of Nursing

Jenny Knecht-Fredo
MSN, CRNP

Jenny Knecht-Fredo is a certified registered nurse practitioner with dual master's degrees in family nurse practitioner studies and nursing education. Jenny has practiced in gerontology, endocrinology, family practice and clinical education. She continues to practice, serving the geriatric population and their families by managing care at a small memory care facility and spends the majority of her time working as a clinical liaison and educator manager for the Long-Term Care Rise 3.0 project. She is passionate about improving care for older adults by connecting, engaging and simultaneously focusing on the 4M evidence-based elements of care when caring for all older adults.

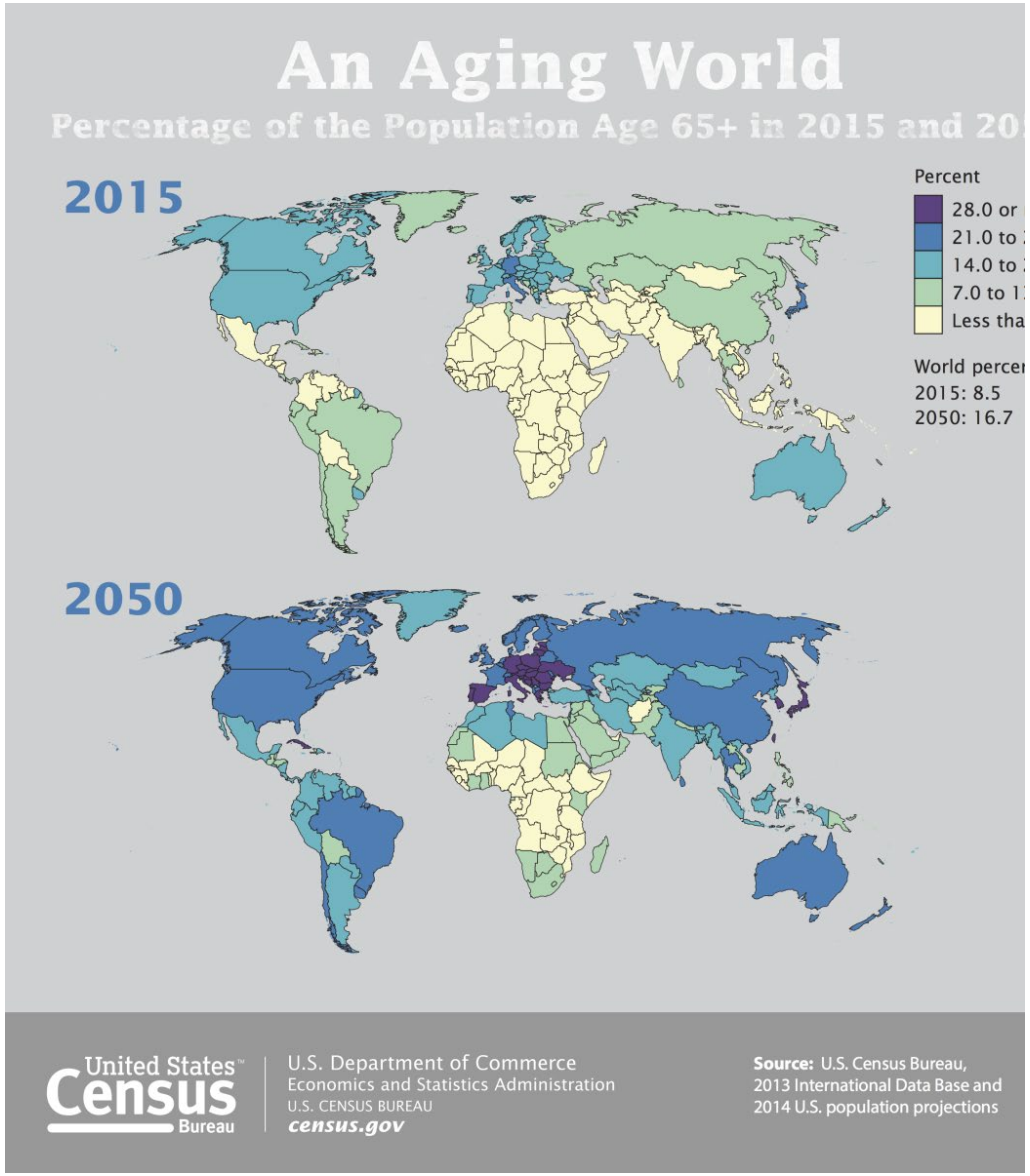
CARE TRANSFORMATION COLLABORATIVE OF RI

JENNY KNECHT-FREDO

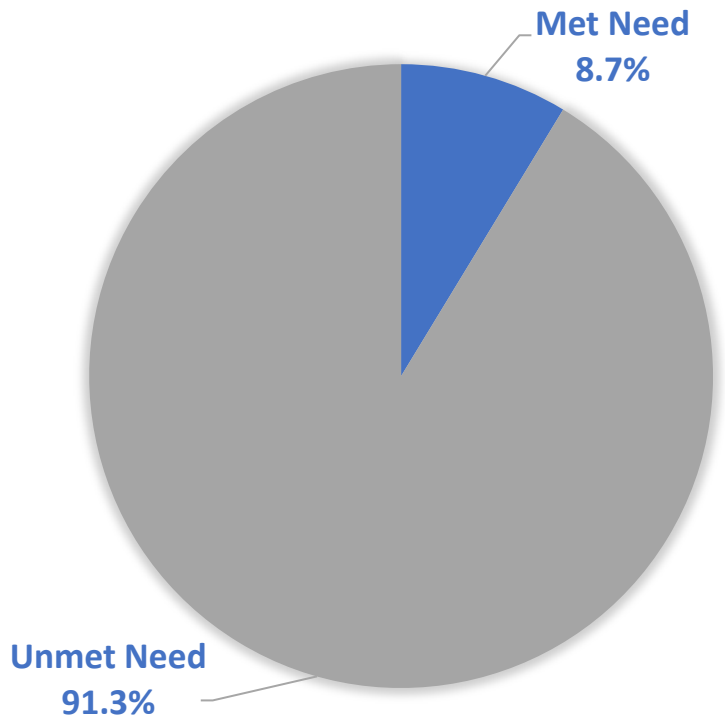
What Does Age-Friendly Mean to You?

Age-Friendly Health Systems

By 2060, the number of Americans >65 years old is expected to double.



Evidence-based care not reliably applied



- We have many evidence-based geriatric-care models of care that have proven very effective
- Yet, most reach only a portion of those who could benefit

IHI analysis of model beneficiaries 2016

Age Friendly Health System

Social movement guided by a set of evidence-based geriatric practice interventions across four core elements, known as the 4 Ms.

AFHS Mission

- Build a movement so all care with older adults is age-friendly care:
  - Guided by an essential set of evidence-based practices (4Ms);
  - Causes no harms; and
  - Is consistent with What Matters to the older adult and their family.

Movement is Focused on Health Equity

IMPROVING PATIENT CARE

Ensuring Equitable Age-Friendly Care

Christina Southey and Luisana Henriquez Garcia

The Age-Friendly Health Systems movement is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States.

Incorporating Health Equity Into An Initiative To Transform Care For Older Adults

Faith Mitchell

JANUARY 14, 2021 10.1377/forefront.20210107.955292

Health Equity in an Age-Friendly Health System: Identifying Potential Care Gaps

Get access >

Emily Morgan, MD ✉, Bryanna De Lima, MPH, Anna Pleet, BS, Elizabeth Eckstrom, MD, MPH

Read: Ensuring Equitable Age-Friendly Care; Incorporating Health Equity Into An Initiative to Transform Care for Older Adults; Health Equity in an Age-Friendly Health System: Identifying Potential Care Gaps

Age-Friendly Health Systems

How is the 4Ms Evidence-Based?

What Matters:

- Asking what matters and developing an integrated systems to address it lowers inpatient utilization (54% dec), ICU stays (80% dec), while increasing hospice use (47.2%) and pt satisfaction (AHRQ 2013)

Medications:

- Older adults suffering an adverse drug event have higher rates of morbidity, hospital admission and costs (Field 2005)
- 1500 hospitals in HEN 2.0 reduced 15,611 adverse drug events saving $78m across 34 states (HRET 2017)

Mentation:

- Depression in ambulatory care doubles cost of care across the board (Unutzer 2009)
- 16:1 ROI on delirium detection and treatment programs (Rubin 2013)

Mobility:

- Older adults who sustain a serious fall-related injury required an additional $13,316 in hospital operating cost and had an increased LOS of 6.3 days compared to controls (Wong 2011)
- 30+% reduction in direct, indirect, and total hospital costs among patients who receive care to improve mobility (Klein 2015)

J Aging Health. 2021 Feb 8;898264321991658. doi: 10.1177/0898264321991658.
Online ahead of print.

Evidence for the 4Ms: Interactions and Outcomes across the Care Continuum

Kedar Mate [1], Terry Fulmer [2], Leslie Pelton [1], Amy Berman [2], Alice Bonner [1], Wendy Huang [3], Jinghan Zhang [3]

Affiliations + expand

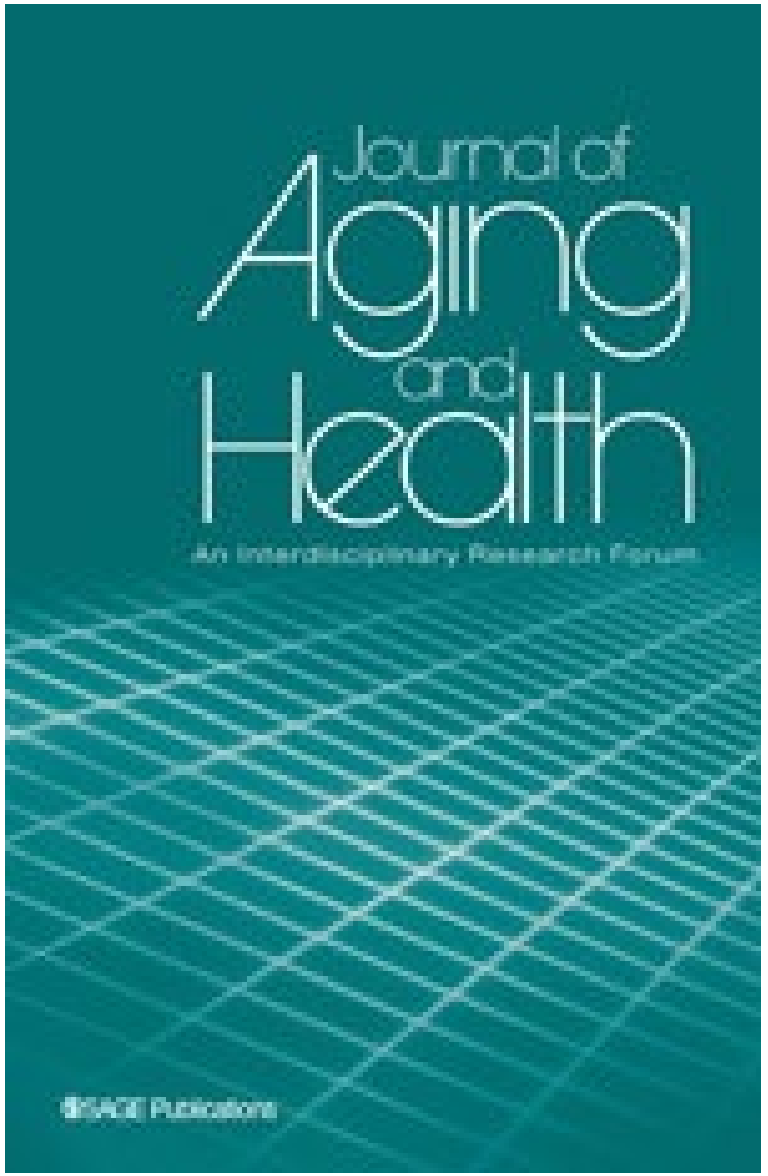
PMID: 33555233 DOI: 10.1177/0898264321991658

Free article

Abstract

Objectives: An expert panel reviewed and summarized the literature related to the evidence for the 4Ms-what matters, medication, mentation, and mobility-in supporting care for older adults. **Methods:** In 2017, geriatric experts and health system executives collaborated with the Institute for Healthcare Improvement (IHI) to develop the 4Ms framework. Through a strategic search of the IHI database and recent literature, evidence was compiled in support of the framework's positive clinical outcomes. **Results:** Asking what matters from the outset of care planning improved both psychological and physiological health statuses. Using screening protocols such as the Beers' criteria inhibited overprescribing. Mentation strategies aided in prevention and treatment. Fall risk and physical function assessment with early goals and safe environments allowed for safe mobility. **Discussion:** Through a framework that reduces cognitive load of providers and improves the reliability of evidence-based care for older adults, all clinicians and healthcare workers can engage in age-friendly care.

Keywords: goal-directed care; quality; safety.



CHALLENGE 2023
START WITH ONE DATA POINT

Key Actions of AFHS in Primary Care

Assess: Know about the 4Ms for each older adult in your care	Act On: Incorporate the 4Ms into the plan of care
Ask What Matters	Align the care plan with What Matters
Document What Matters	Deprescribe or do not prescribe high-risk medications
Review high-risk medication use	Consider further evaluation and manage manifestations of dementia, or refer
Screen for dementia	Identify and manage factors contributing to depression
Screen for depression	Ensure safe mobility
Screen for mobility	

Two Levels of Recognition from IHI

3922

Hospitals, practices, convenient care clinics, and nursing homes have described how they are putting the 4Ms into practices

2096*

Hospitals, practices, convenient care clinics, and nursing homes have shared the count of older adults reached with 4Ms care for at least three months

**Age-Friendly Health System-Participants* count is inclusive of hospitals and practices that went on to be recognized as *Age-Friendly Health Systems-Committed to Care Excellence*

Updated as of April 1, 2024

Age-Friendly Health Systems

CHALLENGE 2024
USE THE 4MS AS A SET. EVERY TIME.

THE 4MS AS A SET

HOLISTIC APPROACH

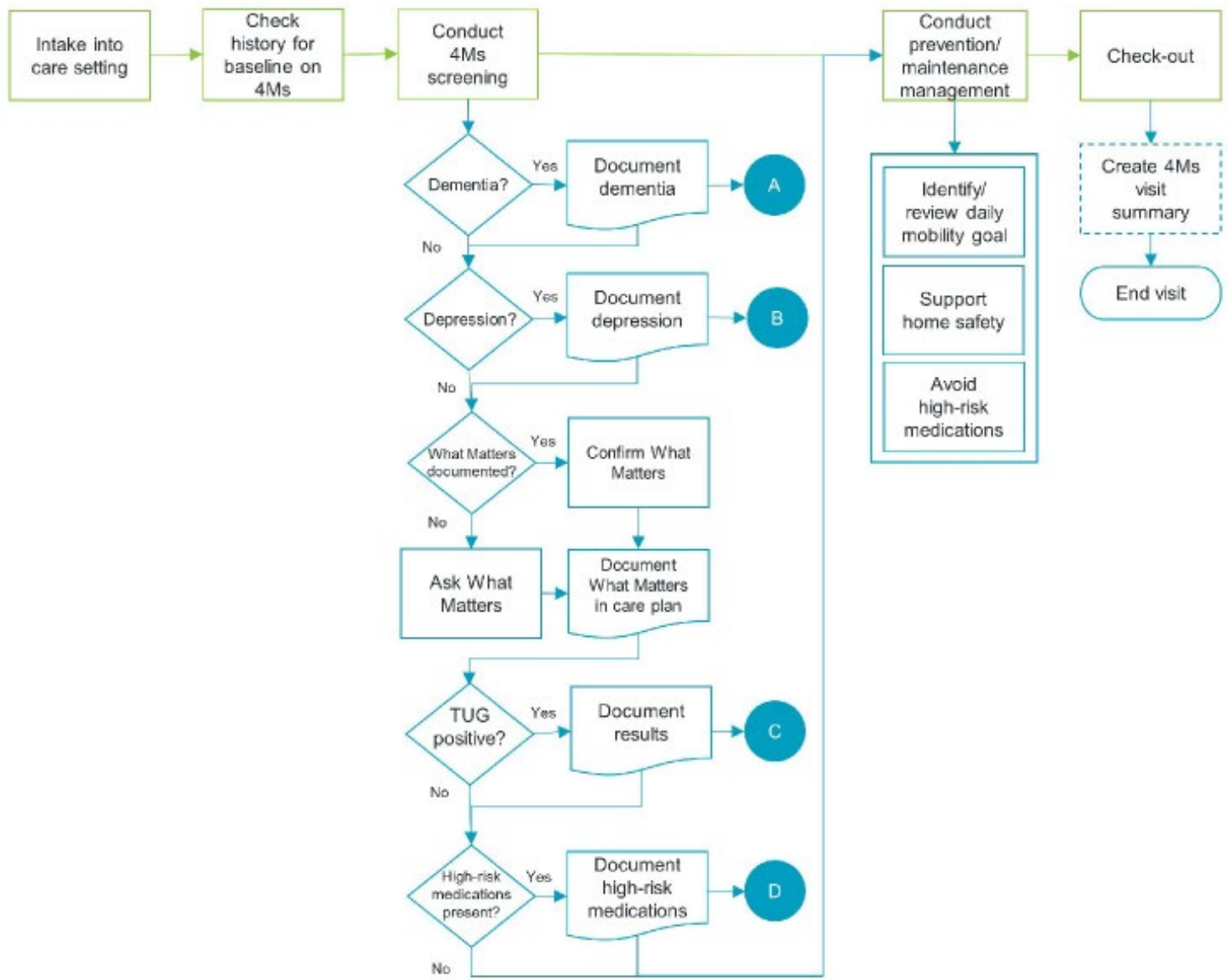
IMPROVED OUTCOMES

EFFICIENCY & EFFECTIVENESS

IMPROVED QUALITY OF LIFE

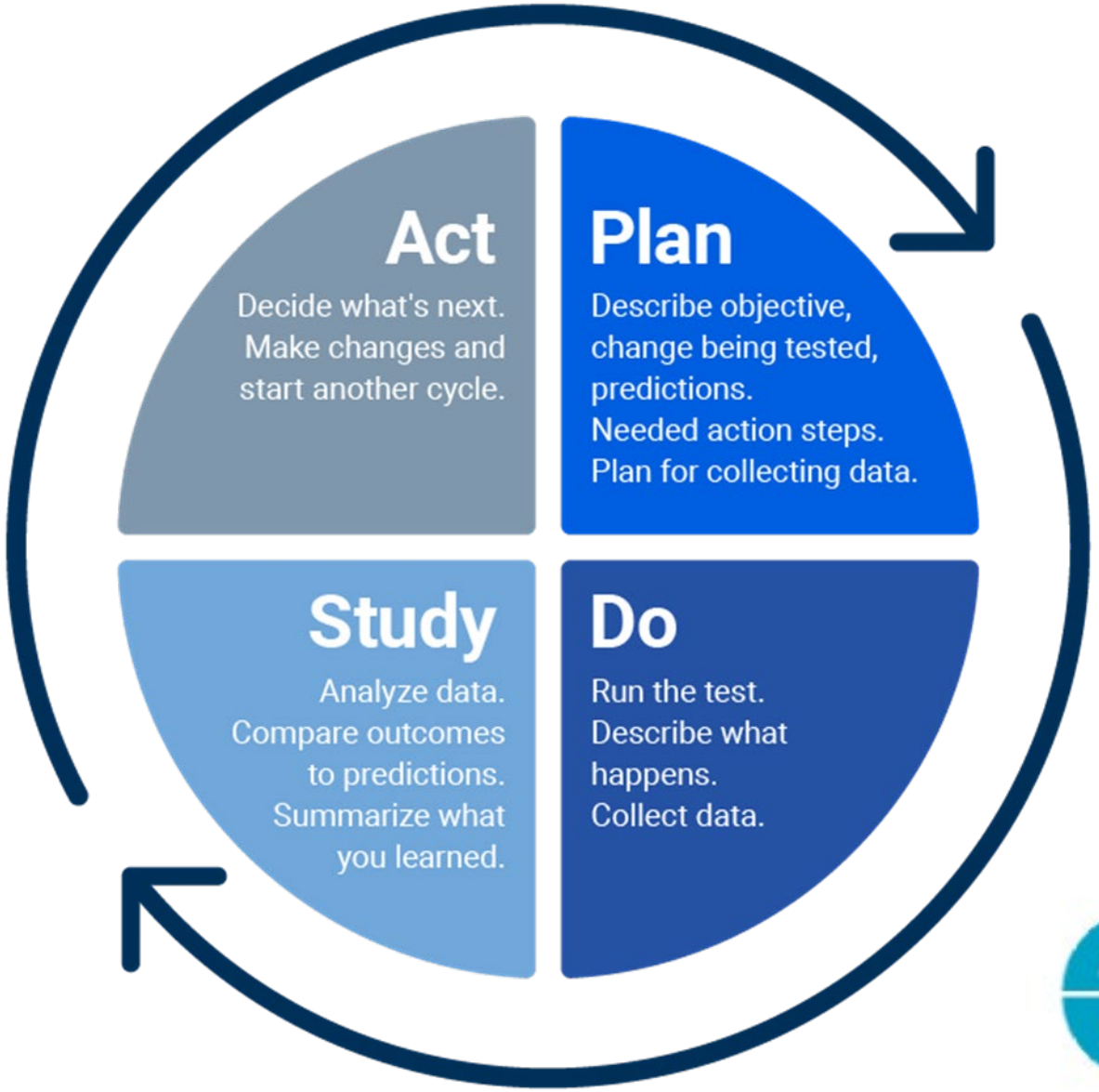
EVIDENCE-BASED PRACTICE

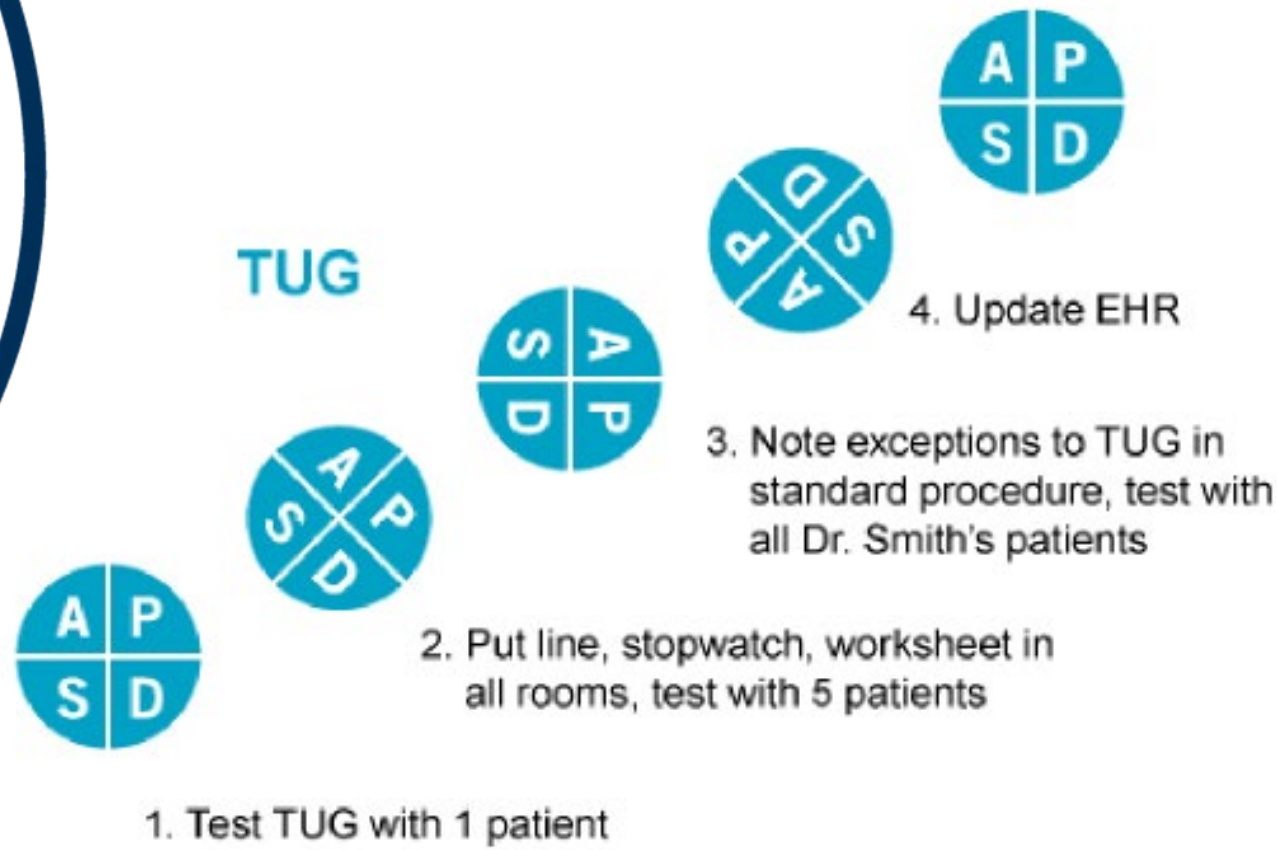
Ambulatory/Primary Care Workflows:
Core Functions for New Patient, Annual Visit, or Change in Health Status



Age-Friendly Health Systems

Our biggest data wins, came from small incremental changes and multiple PDSA’s.


Act
Decide what's next.
Make changes and
start another cycle.
Plan
Describe objective,
change being tested,
predictions.
Needed action steps.
Plan for collecting data.
Study
Analyze data.
Compare outcomes
to predictions.
Summarize what
you learned.
Do
Run the test.
Describe what
happens.
Collect data.


TUG
4. Update EHR
3. Note exceptions to TUG in standard procedure, test with all Dr. Smith's patients
2. Put line, stopwatch, worksheet in all rooms, test with 5 patients
1. Test TUG with 1 patient

My Life • My Health • My Goals
My 4Ms

Health is a team effort, and YOU are in the driver's seat! Complete the 4Ms below and take this sheet with you to your next healthcare visit. Look at your answers before each visit and see if they change over time.

PREFERRED NAME: _____

WHAT MATTERS

Take a moment and think about who you are and what you are facing right now, what is the most important thing that comes to mind?

_____

_____

_____

MEDICATION

Are there any medications that you feel unsure about why you are taking them, or how to take them? List your concerns and questions.

_____

_____

_____

MIND

List two things you do that help you relax, stay calm and be positive.
How do you keep your mind active?

_____

_____

_____

MOBILITY

Set an achievable daily mobility goal for yourself.

_____

_____

4M's Worksheet

My Life • My Health • My Goals
My 4Ms

Make a difference in how your health care works for you by using the **4Ms of Age-Friendly Care:** What Matters, Medications, Mind, & Mobility! The 4Ms are explained below – then flip the page and write your own 4Ms down on the other side. Put your 4Ms on your fridge, update them as needed, and take them with you to all your healthcare visits!

WHAT MATTERS

Receive the best care possible by telling your healthcare providers WHAT MATTERS to you. Think about what is most important to you in life; things you want your health care team to understand about you as an individual. Who are the most important people in your life? What do you view as essential to your quality of health and well-being?

If something were to happen to you, who would you turn to for help making healthcare decisions?

MEDICATION

Understanding your medications and what they do is important. Our bodies change with age in ways that can increase the chances of side effects from medications. One way to help prevent complications from medicine is to understand why you are taking them and to address any concerns about them with your healthcare provider.

MIND

Thinking, memory, and mood matter! Just like your body changes with age, so can your brain. Depression, delirium, and dementia may occur during older adulthood, but they are not a normal part of aging. If you're worried about your memory and thinking, or you are feeling sad a lot, tell your healthcare provider or call the National Helpline at 1-800-662-4357. Find ways to support and engage your mind that reduce stress and anxiety.

For example:

- *Deep breathing*
- *Walking*
- *Doing things that bring you joy*
- *Taking breaks from the news*
- *Helping others by volunteering*
- *Paying attention to nature*
- *Joining a local club or group*
- *Connecting with family, friends, and neighbors*

MOBILITY

Stay as physically active as possible. Set a realistic daily mobility goal, something active you can do every day. This goal may start small and then change as you get more physically active.

For example:

- *Walk outside for 15 minutes every day*
- *Do daily chair exercises for 10 minutes first thing in the morning*
- *Light yoga or tai chi online or with a friend*

Outcomes: Cedars-Sinai Medical Center

In the first year of a program for older adult inpatients with fractures:

- **11 percent reduction in length of stay**
- 41 percent reduction in time of surgery for geriatric inpatients
- $300,000 direct cost-savings

Projected $1 million savings as the program expands to serve 300 patients/year

In Los Angeles, CA. [Read the Issue Brief from the American Hospital Association.]

Age-Friendly Health Systems

“I enjoy when patients are happy with the visits…like when they learn or take something from the visit. Last year, I had an annual wellness visit with a patient on a zoom call. This year, the same patient was able to make it into the visit in person and we had a wonderful chat about how to continue to take care of himself and continue to stay active using his daily mobility goal- walking up and down his steps 3x each day.”

– Nurse from PHN

Providing Age-Friendly Care to Older Adults Open School Course

- The Open School course is completely **free.** It is available here (PFC 203) and through IHI's main page under "New Education Platform."

- The course outlines:
  - Age-friendly care
  - 4Ms Age-Friendly Health Systems Framework
  - Assessment of and action on the 4Ms

- Learners from 45 countries have taken the course.

More than 3,290,000 older adults have been reached with 4Ms care.

As of March 2024

Takeaway

- Is your system already on focusing on an initiative that may align with ONE of the Ms?
- Does your system really value a specific M?
- What does your system find to be alarming or urgent?

Thank You

Age-Friendly Health Systems

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ADVANCING INTEGRATED HEALTHCARE

Participating Practices

PACE-RI, Breakwater Primary Care, Brown Medicine, Family Care Center, University Internal Medicine, Breakwater Primary Care

PACE RHODE ISLAND

Hello

PACE Organization of Rhode Island QI Team
Primary Contact: Emily Drennan
Provider Champion: Dr. George Hardy

What is prompting your interest in this project?
- Our experience during the previous 4M project

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?
- Consistency in practice

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?
- We developed a new way to differentiate between emergency contact and caregiver in our EMR. We've set up a caregiver resources page on our website that includes a lot of educational materials on dementia.

Applying for Level 2 Recognition

	Number	Percent
Number of patients in practice	437	
Patients 65 or over	355	81%
Patients with dx of Dementia/Alzheimer's	150	35%

Breakwater PRIMARY CARE

Hello

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ADVANCING INTEGRATED HEALTHCARE

Breakwater Primary Care QI Team
Primary Contact and Provider Champion: Hugo M Yamada, MD FACP
Site Supervisor: Emilia Lima

What is prompting your interest in this project?

- Practice graduated level 1

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?

- Support staff

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?

- Cognitive decline screening is part of the annual well visit workflow

Applying for Level 2 Recognition

	Number	Percent
Number of patients in practice	6500	
Patients 65 or over	2000	30%
Patients with dx of Dementia/Alzheimer's	200-300	5-10%

BROWN MEDICINE
BROWN PHYSICIANS, INC.

Hello

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ADVANCING INTEGRATED HEALTHCARE

Brown Medicine QI Team
Primary Contact and Provider Champion: Ashna Rajan, MD
Social Worker Liaison: Katherine Johnson

Applying for Level 2 Recognition

What is prompting your interest in this project?

- CTC-RI guided us with Level 1 IHI certification. Our practice and more importantly the co-champions learnt a lot about our practice and what it means to be an age-friendly health system.

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?

- Although we have a plan in place to implement the 4 M framework and achieve Level 2 IHI recognition, we would need assistance with determining an efficient means of documentation and collaborating with our IT team. It would help to understand what has worked for systems in the past and the experience of CTC-RI in implementation of the same.

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?

- We document the name of the care partner in our EMR in a common format, so it is easily accessible. Once the care partners are recognized, a chance to sit down with our integrated behavioral health social worker is offered and resources for caring for people with dementia discussed and provided.

	Number	Percent
Number of patients in practice	1182	
Patients 65 or over	1159	97%
Patients with dx of Dementia/Alzheimer's	221	19%

Care New England

Hello

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Family Care Center QI Team
Primary Contact and Provider Champion: Joanne Wilkinson, MD

What is prompting your interest in this project?

- The Family Care Center treats patients across the life-span and with our ageing local and state population, it is incumbent upon us to provide care that is patient centered, relevant, and efficacious. Delivering Age-Friendly Care, implementing the 4M Model, and supporting Care. 4M's framework will help us in this pursuit.

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?

- The main barrier at the Family Care Center will be developing effective mechanisms for uniform mass adoption of the new model among the nearly 60 primary care providers. In addition, there will be some structural barriers ranging from language translation issues to time constraints to the complications of efficient documentation, associated with using paper rather than on-line patient screening tools.

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?

- We have several configurations of care partners: care partners who are not our patients, but their family member with dementia is; care partners who are our patients and so is their family member; and patients caring for a family member with dementia who is not our patient. In different situations we can provide different types of support but often use our nurse care managers and community health workers to help match caregivers up with community resources.

Applying for Level 2 Recognition

	Number	Percent
Number of patients in practice	4,000	
Patients 65 or over	12,00	30%
Patients with dx of Dementia/Alzheimer's	80	6%

University Internal Medicine

University Internal Medicine QI Team
Primary Contact and Provider Champion: Cheryl Davis, RN NCM
Practice Manager: Addie Fandetti

What is prompting your interest in this project?

- We completed Level 1 4 M s dementia Age Friendly Program and would like to gain more knowledge and assistance with implementing more with dementia care for our patients and their caregivers

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?

- We are a large busy practice with 7 providers . We may find it difficult to be consistent with following through with a consistent plan of care . We may find that caregivers are not compliant . We also may find it difficult to do this project due to being a busy practice

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?

- We currently identify caregivers through the provider appointment with the patient . We also receive information from recent hospital discharge or insurance home visit encounters Family or caretakers will also call with issues and we will identify them that way. We have resources provided through referrals to Alzheimer's association, the POINT and the RI DOH

Applying for Level 2 Recognition

	Number	Percent
Number of patients in practice	5000	
Patients 65 or over	2375	48
Patients with dx of Dementia/Alzheimer's	75-100	1.5-2

Breakwater PRIMARY CARE

Hello

Breakwater Primary Care QI Team
Provider Champion: Gregory J. Steinmetz, MD
Practice Manager: Jamie Handy

What is prompting your interest in this project?
- Improving care of older adults

What barriers do you envision as you implement the 4M framework? What support would be helpful in addressing these barriers?
- N/A

Please describe how you currently identify care partners of patients with dementia and address their needs. What care partner resources and supports do you use or refer to?
- Social workers, NCM, additional resources

Applying for Level 1 Recognition

	Number	Percent
Number of patients in practice	3700	
Patients 65 or over	952	26%
Patients with dx of Dementia/Alzheimer's	28	0.75%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6

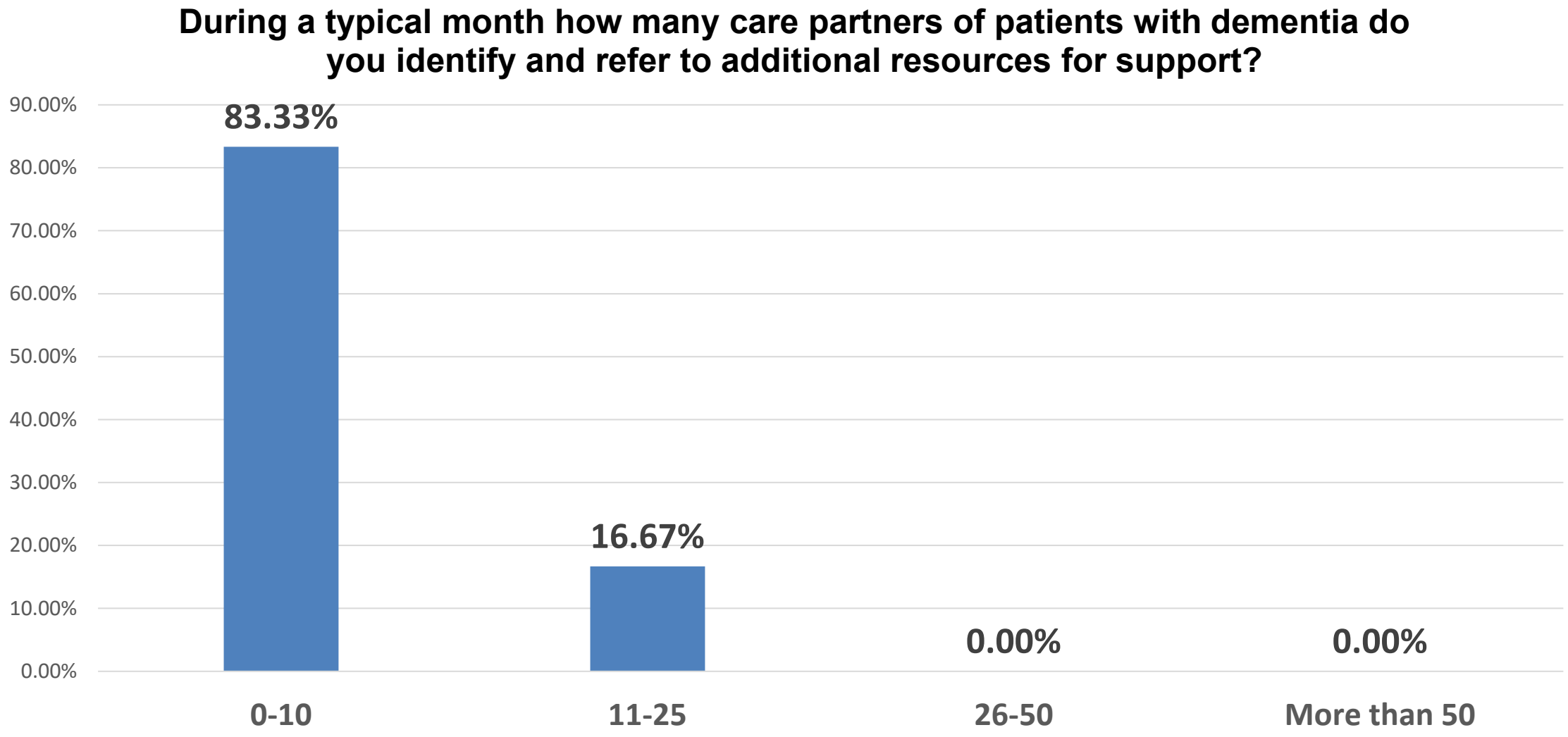
Education and Support for Care Partners for any patients in your practice with Dementia

	Never	Sometimes	Frequently	Always
We identify care partners of patients with dementia and record that information in our EMR.	0.00%	33.33%	33.33%	33.33%
We provide education to care partners of people with dementia and refer them to national and local resources, including the Alzheimer's Association.	0.00%	33.33%	50.00%	16.67%
We identify what matters most to the caregiver and document that in our EMR.	0.00%	66.67%	33.33%	0.00%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6



Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6

4Ms: What Matters

	Never	Sometimes	Frequently	Always
We use specific questions to ask all older adults What Matters most to them and include their health outcome goals and care preferences.	16.67%	33.33%	33.33%	16.67%
We document What Matters Most in the EMR so that this information can be shared across the care team.	16.67%	33.33%	33.33%	16.67%
We align our care with What Matters to each older adult.	16.67%	16.67%	66.67%	0.00%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6

4Ms: Medication

	Never	Sometimes	Frequently	Always
We review all medications at least yearly and specifically check to see whether they are in one of these high-risk categories. (Benzodiazepines, Opioids, Highly-anti-cholinergic medications, Rx and OTC sleep medications and sedatives, Muscle relaxants, Tricyclic antidepressants, Antipsychotics, Mood stabilizers)	0.00%	0.00%	33.33%	66.67%
We identify high-risk medication use and take at least one of the following steps: -Deprescribe or reduce the dose if possible. -Educate the patient on the potential risks of the medication -Refer for additional support, such as to a pharmacist	0.00%	0.00%	50.00%	50.00%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6

4Ms: Mentation (dementia and depression)

	Never	Sometimes	Frequently	Always
At least annually, we screen and/or assess all older adults for dementia using an evidence-based tool such as the Mini-Cog, SLUMS or MOCA and document results in the EMR.	0.00%	16.67%	33.33%	50.00%
We share the screening results with the patients and either provide educational resources or refer to community organizations for resources and support.	0.00%	16.67%	0.00%	83.33%
We screen all older adults for depression at least annually using the PHQ2, PHQ9, or GDS and record results in the EMR.	0.00%	0.00%	0.00%	100.00%
If the depression screen is positive, we educate the older adult about depression, and/or consider prescribing an anti-depressant.	0.00%	0.00%	33.33%	66.67%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6

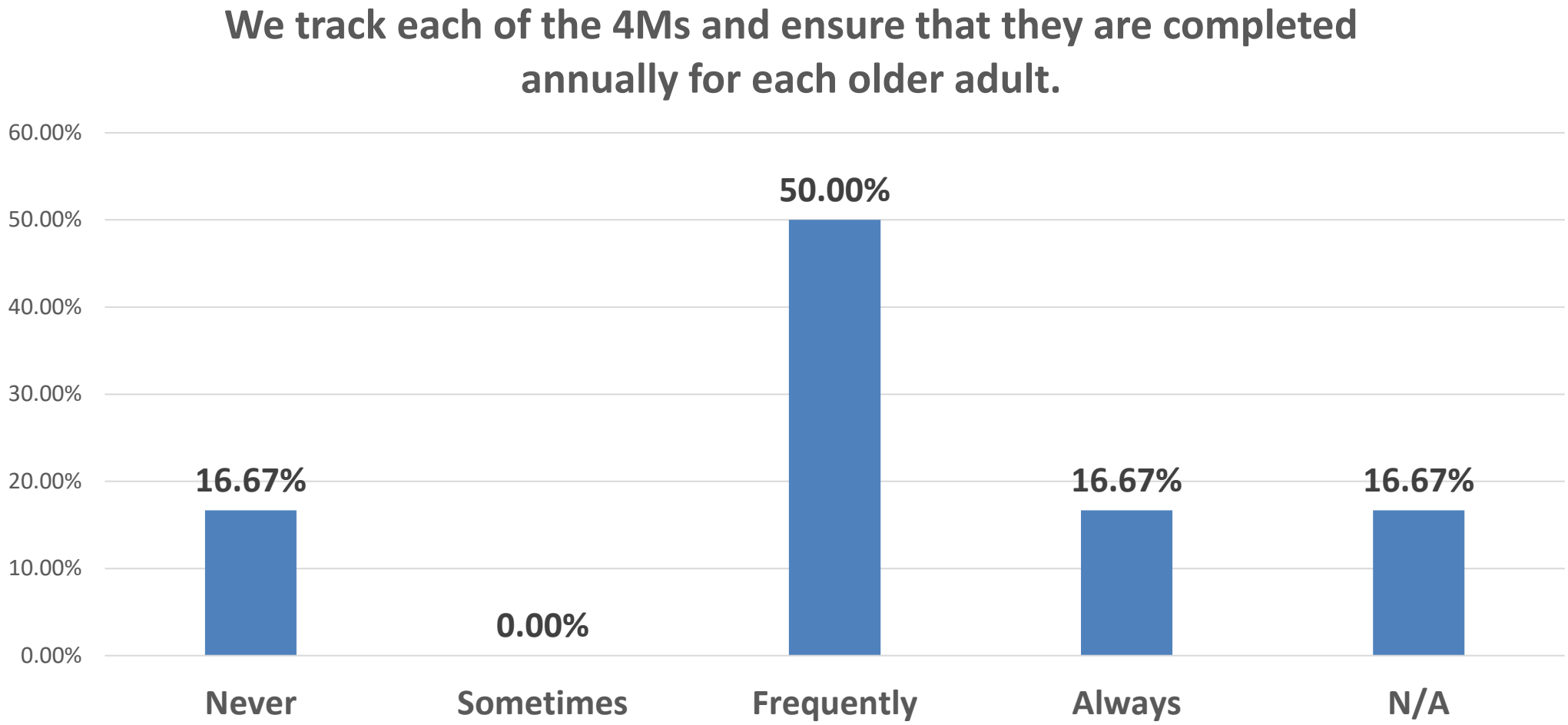
4Ms: Mobility

	Never	Sometimes	Frequently	Always
We assess all older adults for mobility at least yearly using evidence-based tool(s) such as the TUG, Tinetti, or JH-HLM.	16.67%	16.67%	16.67%	50.00%
If a screen is positive, we do either a multifactorial fall protection protocol, such as the STEADI or at least three of the following: - Educate older adult and caregivers - Set a daily mobility goal that supports what matters and review progress toward the goal -Manage pain, gait, balance, and strength impairments that may reduce mobility -Ensure that the home is safe for mobility-Avoid high-risk medications-Refer to physical therapy	0.00%	33.33%	16.67%	50.00%

Pre-Assessment Results

ADVANCING INTEGRATED HEALTHCARE

# of respondents: 6



Milestone: Level 1 and 2

Delivering Age-Friendly Care
Implementing the 4M Model and Supporting Care Partners of People with Dementia:
A Path to 1 or Level 2 Recognition from the Institute for Health Care Improvement
Level 1

Milestone Summary

This six-month quality improvement initiative focuses on a) developing a plan to implement the 4Ms of age-friendly care: What Matters, Mentation, Mobility, and Medication and b) identifying caregivers of patients with dementia and providing resources based on what is helpful to them. The program will culminate with applying for IHI Level 1 recognition.

Milestone Summary

Component	Deliverable	Due Dates	Notes, Links, and Documents
Pre-Initiative work	• Identify a quality improvement (QI) team with three to four staff members in different roles, such as clinical champion, nurse care manager/care coordinator, practice manager, behavioral health clinician, and IT representative if available. • Complete pre-post assessment • Submit participative agreement	**September 4, 2024**	
Three learning collaboratives 1. Kickoff (90 minutes) 2. Mid-point (60-90 minutes) 3. Wrap-up (60-90 minutes) **Six practice facilitation (PF) meetings** (Sep 2024-Feb 2025)	• Attend learning collaborative meetings • Attend PF meetings	**Learning Collaborative Meetings** **1. September 10, 2024**, 7:30-9:00 am **2. November 14, 2024**, 7:30-8:30/9:00 am **3. February 20, 2025,** 7:30-8:30/9:00 am	Join Zoom Meeting Meeting ID: 878 5732 3745 Passcode: 646876
Five PDSA cycles	• 1 PDSA for identification and education of caregivers for people with dementia • 4 PDSAs (one for each of the 4Ms)	**November 1, 2024** (Caregiving PDSA) **February 1, 2025** (PDSAs for all 4Ms)	PDSA- To be distrubted with Participant Agreement post selection
Program evaluation	Pre-post assessment	**February 13, 2025**	
Level 1 recognition	**Submit IHI application:** Ambulatory 4Ms Forms.pdf (ihi.org)	**February 28, 2025** (Final payments will be issued after the application has been submitted to IHI and all other deliverables have been met.)	Confirmation of recognition generally occurs two-three weeks after submission of application.

View Level One

Delivering Age-Friendly Care
Implementing the 4M Model and Supporting Care Partners of People with Dementia:
A Path to 1 or Level 2 Recognition from the Institute for Health Care Improvement
Level 2
Milestone Summary

This six-month quality improvement initiative focuses on and a) implementing the 4Ms of age-friendly care for all older adults in your practice: What Matters Most, Mentation, Mobility, and Medication and b). identifying and supporting care partners of patients with dementia. The initiative will culminate in the application for IHI Level 2 recognition.

Component	Deliverable	Due Dates	Notes, Links, and Documents
Pre-Initiative Work	• Identify a quality improvement (QI) team. The team should consist of three to four staff members in different roles, such as clinical champion, nurse care manager/care coordinator, practice manager, behavioral health clinician, and/or IT representative if available. • Complete pre-post assessment • Submit participative agreement	**September 4, 2024**	
Three Learning Collaborative Meetings: 1. Kickoff (90 minutes) 2. Mid-point (60-90 minutes) 3. Wrap-up (60-90 minutes) **Six practice facilitation (PF) meetings** (Sep 2024-Feb 2025)	• The QI team will attend learning collaborative meetings and monthly practice facilitation meetings.	**Learning Collaborative Meetings** **1. September 10, 2024**, 7:30-9:00 am **2. November 14, 2024**, 7:30-8:30/9:00 am **3. February 20, 2025,** 7:30-8:30/9:00 am	Join Zoom Meeting Meeting ID: 878 5732 3745 Passcode: 646876
Two PDSA/Case Study	• PDSA and Case Study for identification and education of care partners for people with dementia • PDSA and Case Study (4Ms)	• **November 1, 2024 (Caregiving PDSA)** • **February 1, 2025 (PDSAs for all of the 4Ms)**	PDSA- To be distrubted with Participant Agreement post selection
Program evaluation	Pre-Post Assessment	**February 13, 2025**	
Level 2 recognition	**Submit IHI worksheet-** To be distrubted with Participant Agreement post selection	**February 28, 2025** (Final payments will be issued after the application has been submitted to IHI and all other deliverables have been met.)	Confirmation of recognition generally occurs two-three weeks after submission.

View Level Two

Resource Guide

View Resource Guide

The Next Building Block Resource Guide

Resource	Description and key links
Patient / Care Partner Resources	
Alzheimer's Association 24/7 Helpline: 800.272.3900	The Alzheimer's Association (www.alz.org) provides education and support to those facing Alzheimer's and related dementias throughout the state, including those living with the disease, caregivers, health care professionals and families. • Alzheimer's Association, RI Chapter (RIAA) – The RIAA office is located in Providence and serves the entire state of Rhode Island • Caregiving – Downloadable Publications This page provides a variety of information on a wide range of topics • Family Care Guide Offers helpful information and resources for those living with or caring for someone with Alzheimer's or related dementias • Home Safety Checklist • Educational Programs and Care Resources – Offers free in-person and virtual education programs
Alzheimer's Association's Dementia Care Coordination Program	The Dementia Care Coordination (DCC) Program is an evidence-based program that provides vital support to family caregivers who are caring for a loved one living with Alzheimer's disease. Providers can refer care partners to the program through an online, HIPAA-compliant portal. • DCC Referral Assessment Tool • DCC Electronic, HIPAA-compliant referral form • Sample of Consultation Summary; Sample Follow up Letter with Recommendations
CareBreaks Respite Program	Offered through the Catholic Diocese of RI Elder Services, the *CareBreaks* Program (401-421-7833, Ext. 212) provides assistance with finding and paying for someone to step in and fill the caregiver's shoes, either on a one time or regular basis. • CareBreaks Program Flyer • CareBreaks Application
RIDOH Community Health Network	This is a free, six-week class offered through the Community Health Network at RIPIN to provide care partners with the skills to take care of themselves while caring for someone else. • Powerful Tools for Caregivers Program
CareLink of RI	CareLink offers evidence-based therapeutic programs for residents of Rhode Island who are living with dementia. These programs take place in the comfort of a resident's home (or if preferred, in our outpatient clinic) and are free of charge. • Therapeutic Services for Dementia • ADPI Dementia Program
Institute for Healthcare Improvement	The Conversation Project, an Initiative of the Institute for Healthcare Improvement has developed a guide to help prepare care partners to make health care decisions as the need arises. • Your Conversation Start Guide – For Caregivers of People with Alzheimer's or Other Forms of Dementia
National Institute on Aging	The below guide from NIA may be a helpful resource for caregivers. Available in English and Spanish and paper copies can be ordered through their website. • Caring for a Person with Alzheimer's Disease • Order Free Publications – related to ADRD

Discussion, Questions, & Next Steps

- **Learning Collaboratives**:
  7:30 AM - 9:00 AM

- Midpoint: **November 14th, 2024**
- Wrap up: **February 20th, 2025**

- **Practice Facilitator Meetings** to be scheduled monthly individually with PF and practices **(Sept 2024-Feb-2025)**

- **Post Assessment Due:** February 13th, 2025

THANK YOU

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