 Integrating the 4Ms into clinical practice: What Matters

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Goals

- Apply What Matters as part of the Geriatric 4Ms
- Evaluate What Matters in older adults
- Create an Action Plan to align What Matters with health care
WHAT MATTERS

Improve the fit!
Improving the mask fit: flexible brace

Improve the fit: nose wires

Alcohol sanitize hands prior to wire adjustment

Fog prevented by wire over the nose
Improving the fit: knotting and bracing

N95 masks

Concern about fake KN95ers
To preserve N95ers: 8 uses as on – off
Not effective with beards
15% fail a fit test
Double mask

Vaccinate

Fauci Ouchie
To be effective, the 4Ms need to be practiced as a set

What matters may depend upon perspective

Provider

Patient / Care giver
Conundrum: providers’ perspective

- Focus on code status
- Status changes in acute situations
- Ignored in ED
- Time consuming

What Matters depends on older adult’s

- Life Expectancy
- Functional status
- Disposition

Centenarians
Lifespan calculators
Disease – specific calculators

Opportunities to engage older adults with What Matters

- Annual Wellness Exam
- Group visits with the PCMH
- ACP referral
- Resources
  - On – line
  - Packets
Innovations: Sanford Health AWE

- Team – based
- Kiosk stations

PT  PharmD

Social work  APN

Implementing the 4Ms

- Some elements already being done
- Goal is to amplify and consistently apply
How to implement 4Ms and What Matters?

- Process
- Ownership
- Work flow

Documentation

Assessment
- What Matters
- ACP
- POLST
- Stanford Letter
- Mobility
  - Gait speed / TUG
- Medication
  - Beers List review
- Mentation
  - Mini-cog
  - PHQ-2

Management
- ACP consultation
- Physical therapy referral
- Deprescribe
- Memory clinic referral
- Caregiver training
How do you know if 4Ms are being consistently applied?

<table>
<thead>
<tr>
<th>Date</th>
<th>All 4Ms</th>
<th>What Matters</th>
<th>Medications</th>
<th>Depression</th>
<th>Dementia</th>
<th>Mobility</th>
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What Matters

Pragmatic  →  Aspirational
Boosting the health care triad for What Matters

Direct care worker roles to support What Matters

- Educate older adult and caregiver
- Provide resources
- Review 4Ms with each encounter
Getting the ball rolling

“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?

If life expectancy not long…..

“What are your most important goals if your health situation worsens?”
Assessing What Matters: Swedish checklist

<table>
<thead>
<tr>
<th>Activity</th>
<th>What has been your level of interest</th>
<th>Do you currently participate in this activity?</th>
<th>Would you like to pursue this in the future?</th>
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<tr>
<td></td>
<td>In the past ten years</td>
<td>In the past year</td>
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<td>Gardening/Yardwork</td>
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<tr>
<td>Sewing/hobby craft</td>
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<tr>
<td>Playing card</td>
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<td>Foreign languages</td>
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<td>Church activities</td>
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<td>Radio</td>
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<td>Walking</td>
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<td>Listening to popular music</td>
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<tr>
<td>Reading</td>
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British check list

<table>
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<tr>
<th>Category</th>
<th>Activity</th>
<th>Degree of interest</th>
<th>Participation</th>
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<td></td>
<td></td>
<td>Strong</td>
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</tr>
<tr>
<td>Health &amp; Houses</td>
<td>Smoking, alcohol</td>
<td>Strong</td>
<td>Some</td>
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<tr>
<td></td>
<td>Eating</td>
<td>Strong</td>
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<td>Sleep</td>
<td>Strong</td>
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<td>Other Health and Health</td>
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<td>Sports</td>
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<tr>
<td></td>
<td>Other Professional &amp; Employment</td>
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</table>
Activity Categories

• Outdoor activities
• Creativity & Handicrafts
• Home based activities
• Physical exercise
• Social activities
• Other activities

Creativity and handicrafts

• Woodworking / Metalworking
• Photography
• Solving crossword / puzzles / sudoku
• Painting / Drawing
• Collecting (stamps, porcelain figures, toys etc.)
• Scrapbooking
• Creating movies / music / podcasts
• Writing (letters, texts etc.)
• Knitting / Crocheting
• Sewing / Embroidering (Needle work)
Social Activities

- Club activity / Volunteering
- Participating in religious events
- Spectator sports
- Cultural events
- Going to Movies
- Dining out: restaurants, cafes
- Attending public lectures
- Social media
- Choir / singing
- Playing board games
- Spending time with family
- Spending time with friends

What Matters: ADLs and IADLs

![Bar chart showing limitation in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) across different age groups. The chart displays percentage values for age groups 18-44 yrs, 45-64 yrs, 65-74 yrs, and ≥75 yrs, with error bars indicating variability.](image)
What Matters depends on living situation

### Number of ADLs Supported by Percent of Residents in Assisted Living

<table>
<thead>
<tr>
<th>Percent of Residents</th>
<th>0 ADLs, 35%</th>
<th>1 ADL, 24%</th>
<th>2 ADLs, 14%</th>
<th>3 ADLs, 10%</th>
<th>4 or 5 ADLs, 13%</th>
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</thead>
</table>

Source: AI Data from 2009 NHLA, National Alzheimer's Care Registry.

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**ADL Assessment**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient ID #:</th>
<th>Date:</th>
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**Katz Index of Independence in Activities of Daily Living**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Independence (0 Points)</th>
<th>Dependence (0 Points)</th>
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<tbody>
<tr>
<td>BATHING Points:</td>
<td>(0 POINTS) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or extremities. May have help getting out of tub or shower. Requires total bathing</td>
<td></td>
</tr>
<tr>
<td>DRESSING Points:</td>
<td>(1 POINTS) Gets clothes from closet and puts on clothes and shoes; grooms self complete with fasteners. May have help tying shoelaces.</td>
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<tr>
<td>TOILETTING Points:</td>
<td>(1 POINTS) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.</td>
<td></td>
</tr>
<tr>
<td>TRANSFERRING Points:</td>
<td>(1 POINTS) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.</td>
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<tr>
<td>CONTINENCE Points:</td>
<td>(1 POINTS) Excretes complete self control over urination and defecation.</td>
<td></td>
</tr>
<tr>
<td>FEEDING Points:</td>
<td>(1 POINTS) Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL POINTS:**

**SCORING:**

- 6 = High (patient independent)
- 4 = Moderate (patient needs assistance)
- 2 = Low (patient needs substantial assistance)
- 0 = Very Low (patient needs total assistance)
INSTRUMENTAL ACTIVITIES OF DAILY LIVING

The IADLs are assessed using the Lawton-Brody instrumental activities of daily living (IADL) scale.

- Telephone
- Traveling
- Shopping
- Preparing meals
- Housework
- Medication
- Money

The Ours Methodology: Multidimensional Functional Assessment Questionnaire; 1978.

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Stanford Letter

What Matters Most to Me
Examples: Being at home, doing gardening, going to church, playing with my grandchildren

My important future life milestones:
Examples: my 10th wedding anniversary, my grandson high school graduation, birth of my granddaughter

Here is how we prefer to handle bad news in my family
Examples: We talk openly about it, we shield the children from it, we do not like to talk about it, we do not tell the patient

Here is how we make medical decisions in our family
Examples: I make the decision myself, my entire family has to agree on major decisions about me, my daughter who is a nurse makes the decisions etc.
End of Life or Acute illness planning for what matters

Percent of patients with Advance Care Plans

- 28% of home care patients
- 65% of nursing home residents
- 80% of hospice
**A. Cardiopulmonary Resuscitation Orders.** Follow these orders if patient has no pulse and is not breathing.

- **Yes CPR:** Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)
- **No CPR:** Do Not Attempt Resuscitation. (May choose any option in Section B)

**B. Initial Treatment Orders.** Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

- **Full Treatments** (required if choose CPR in Section A). Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
- **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
- **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

**D. Medically Assisted Nutrition.** (Offer food by mouth if desired by patient, safe and tolerated)

- [ ] Provide feeding through new or existing surgically-placed tubes
- [ ] No artificial means of nutrition desired
- [ ] Trial period for artificial nutrition but no surgically-placed tubes
- [ ] Not discussed or no decision made (provide standard of care)
Advance Care Plan

- Durable Power of Attorney
- Living Will
  - CPR preference
  - Ventilator?
  - IV or artificial nutrition

Quality Improvement and Advance Care Planning

- Goal to have 100% of patients complete their ACP and POLST
- Identify targeted population (e.g., all 65+ year olds)
- Determine % of population approached about ACP
- Determine % of patients with ACP discussion who do not have documented ACP
Root Cause Analysis

- People
- Environment
- System issues
- Methods

Quality Improvement

- Step 1: Identify the problem
- Step 2: Describe care consistent with the 4Ms
- Step 3: Design or adapt your workflow
- Step 4: Provide care
- Step 5: Study your performance
- Step 6: Improve and sustain care
PDSA cycle for ACP Quality Improvement

- Organize team
- Small targeted intervention, for example
  - all patients 85 +
  - 2 or 3 provider practices
- State Intervention, for example
  - All 85 + patients will be provided an ACP packet and referred to an ACP ambassador

Summary

- Know and align care with each older adult’s specific health outcome goals and care preferences
- Practice the 4Ms consistently