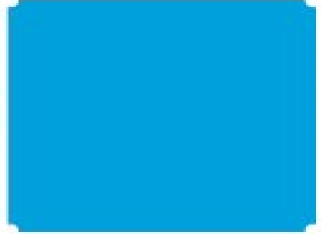
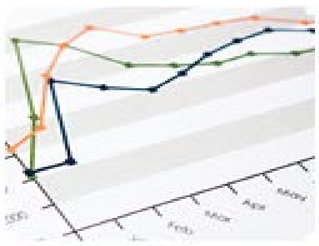
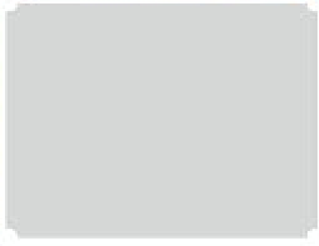
Oklahoma Dementia Care Network (OkDCN)

# IHI Age-Friendly Recognition What Matters Most, Medication, Mentation & Mobility







OFMQ

ADVANCING QUALITY » IMPROVING LIVES

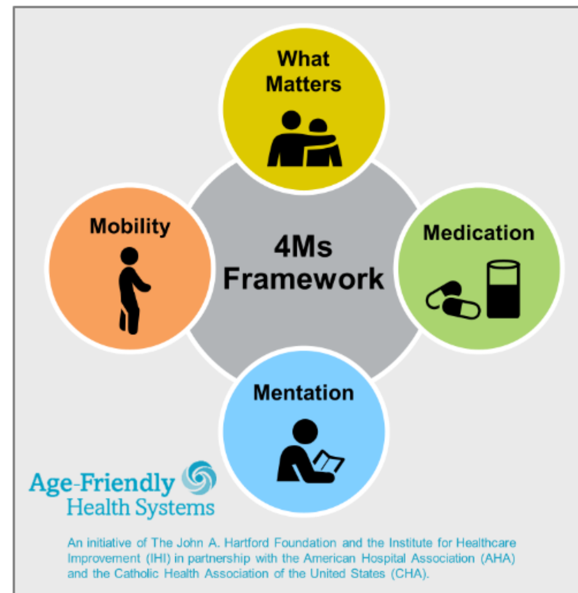
# Whole System Quality a Tiered approach

| Quality Planning | Quality Control | Quality Improvement | |
|---|---|---|---|
| Offer input to inform organizational strategy as primary customer group | Offer feedback on quality experience to inform understanding of performance | Engage as co-producer in relevant QI activities | **Patients, Families, and Communities** |
| POINT OF CARE | | | |
| Inform plans and requirements to execute on the strategy locally | Identify and solve problems as they arise (gaps with standard), escalate as necessary | Lead and engage in local QI activities and identify potential QI projects | **Clinicians** |
| Translate strategy into a plan for unit setting and outline requirements for execution | Monitor performance and direct solutions, escalate problems as necessary | Lead QI projects and capture ideas for potential QI work | **Unit-Level Leaders** |
| Facilitate strategic planning process, support research and analysis activities | Support development of QC standard work and infrastructure | Support local QI activities and inform project prioritization efforts | **Quality Department Staff** |
| Work with executives and unit leaders to articulate how to execute on strategy | Identify cross-cutting problems and trends close feedback loops | Sponsor QI projects, lead cross-cutting QI efforts | **Departmental Leaders** |
| Identify customers, prioritize needs, and develop strategy | Mobilize resources to address emergent and cross-cutting problems | Sponsor and commission prioritized QI projects | **Executive Leaders** |
| Ensure organizational strategy is quality-centric | Review quality performance on a regular basis | Review performance of major QI projects on a regular basis | **Board of Directors** |

# IHI Age-Friendly Health System Recognition

**GOAL:**

**Create health care systems that ensure every older adult receives the best evidence-based care possible, without harm, ultimately satisfied with the care received.**




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.

- *https://www.ihi.org/initiatives/age-friendly-health-systems/recognition*

# Process:  Age-Friendly Care Description Worksheet

| What Matters Most | Medication | Mentation | Mobility |
|---|---|---|---|
| Screening Tools | Screening Tools | Screening Tools | Screening Tools |
| Frequency | Frequency | Frequency | Frequency |
| Documentation | Documentation | Documentation | Documentation |
| Act On | Act On | Act On | Act On |
| Primary Responsibility | Primary Responsibility | Primary Responsibility | Primary Responsibility |

# What Matters

**Aim:** 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

**Assess:** Ask What Matters
List the question(s) you ask to know and align care with each older adult's specific outcome goals and care preferences:
- View guiding questions from What Matters Toolkit

Minimum requirement: One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life.

**Frequency for Nursing Facility (NF):**
Minimum frequency is upon admission and change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

**Frequency for Skilled Nursing Facility (SNF):**
Minimum frequency is upon admission, change of condition, and daily for the first 14 days.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Daily for first 14 days
- ☐ Other

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other

**Act On:**
Minimum requirement: First box must be checked.

- ☐ Align the care plan with What Matters most
- ☐ Other

**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ Social Worker
- ☐ MD/PA/ Nurse Practitioner
- ☐ Other

# Assessment of What Matters Most

**Assess:** Ask What Matters

List the question(s) you ask to know and align care with each older adult's specific outcome goals and care preferences:

- View guiding questions from What Matters Toolkit

Minimum requirement: One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life.

# What Matters Questions

- What is important to you today?
- What brings you joy?
- What makes you happy?
- What makes life worth living?
- What do you worry about?
- What are some goals you hope to achieve in the next six months or before your next birthday?
- What would make tomorrow a really great day for you?
- What else would you like us to know about you?

# Medication

**Aim:** 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

**Screen / Assess:**
Check the medications you screen for in all older adults.
Minimum requirement: All eight boxes must be checked.

- ☐ Benzodiazepines, Anxiolytics
- ☐ Opioids
- ☐ Highly-anticholinergic medications (e.g., diphenhydramine)
- ☐ All prescription and over-the-counter sedatives and sleep medications (hypnotics)
- ☐ Muscle relaxants
- ☐ Tricyclic or other antidepressants
- ☐ Antipsychotics
- ☐ Mood Stabilizers
- ☐ Other

**Frequency:**
Minimum frequency is upon admission and upon change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other

**Act On:**
Minimum requirement: At least one box must be checked.

- ☐ Deprescribe (includes both dose reduction and medication discontinuation)
- ☐ Monitor prescribing and reduce dose of high risk medication
- ☐ Other

**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ MD/PA/ Nurse Practitioner
- ☐ Pharmacist
- ☐ Other

# Mentation: Cognitive Impairment (dementia or related disorders)

**Aim:** Prevent, identify, treat, and manage cognitive impairment across settings of care.

**Screen:**
Check the tool used to screen for Cognitive Impairment for all older adults.
Minimum requirement: At least first box must be checked. If only "Other" is checked, will review.

- ☐ Mini-Cog
- ☐ BIMS (included in MDS)
- ☐ Other

**Assess:**
Check the tool used to assess for Cognitive Impairment.
Minimum requirement: If screen is positive, conduct assessment. If only "Other" is checked, will review

- ☐ SLUMS
- ☐ MOCA
- ☐ Other

**Frequency:**
Minimum frequency is upon admission and upon change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other

**Act On:**
Minimum requirement: Must check first two boxes.

- ☐ Share results with older adult and, if appropriate, with caregiver
- ☐ Manage behaviors related to cognitive impairment (non-pharmacological approaches) : Describe below
- ☐ Provide educational materials to older adult and care partner
- ☐ Other

**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ Social Worker
- ☐ MD/PA/ Nurse Practitioner
- ☐ Pharmacist
- ☐ Mental or Behavioral Health Provider
- ☐ Other

# Mentation: Depression

**Aim:** Prevent, identify, treat, and manage depression across settings of care.

**Screen / Assess:**
Check the tool used to screen for depression for all older adults.
Minimum requirement: At least one of the first four boxes must be checked. If only "Other" is checked, will review

- ☐ Patient Health Questionnaire (PHQ)-2
- ☐ Patient Health Questionnaire (PHQ)-9
- ☐ Geriatric Depression Scale (GDS) - short form
- ☐ Geriatric Depression Scale (GDS)
- ☐ Other

**Frequency:**
Minimum frequency is upon admission and upon change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other

**Act On:**
Minimum requirement: Must check first two boxes.

- ☐ Educate older adult and, if appropriate, caregiver
- ☐ Manage factors related to depression (non-pharmacological approaches)
- ☐ Consider recommending anti-depressant
- ☐ Refer to:
- ☐ Other

**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ Social Worker
- ☐ MD/PA/ Nurse Practitioner
- ☐ Mental or Behavioral Health Provider
- ☐ Other

# Mentation: Delirium

**Aim:** Prevent, identify, treat, and manage delirium across settings of care.

**Screen / Asses:**
Check the tool used to screen for delirium for all older adults.
Minimum requirement: At least one must be checked. If "other" is checked, will review.

- ☐ UB-CAM
- ☐ CAM (Included in MDS)
- ☐ Other

**Frequency for Nursing Facility (NF):**
Minimum frequency: First two boxes must be checked. If "other" is checked, will review.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

**Frequency for Skilled Nursing Facility (SNF):**
Minimum frequency: First three boxes must be checked. If "other" is checked, will review.

- ☐ At admission
- ☐ Every 24 hours
- ☐ Upon change of condition
- ☐ Other

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other

**Act On:**
Delirium prevention and management protocol including, but not limited to:
Minimum requirement: Must check first five boxes.

- ☐ Ensure sufficient oral hydration
- ☐ Orient older adult to time, place, and situation on every nursing shift, if appropriate
- ☐ Ensure older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers)
- ☐ Prevent sleep interruptions, use non-pharmacological interventions to support sleep
- ☐ Avoid high-risk medications
- ☐ Other

**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ MD/PA/ Nurse Practitioner
- ☐ Other

# Mobility

**Aim**: Ensure that each older adult moves safely every day to maintain function and do What Matters.

**Screen / Assess:**
Check the tool used to screen for mobility limitations for all older adults.
Minimum requirement: One box must be checked. If screening/assessment is done by physical therapy, please identify the tool used. If only "Other" is checked, will review.

- ☐ Timed Up & Go (TUG)
- ☐ Johns Hopkins High Level of Mobility (JH-HLM)
- ☐ Tinetti Performance Oriented Mobility Assessment (POMA)
- ☐ Screening and assessment forms per physical therapy ____
- ☐ Other ____

**Frequency:**
Minimum frequency is upon admission and change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other ____

**Documentation:**
Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other ____

**Act On:**
Minimum requirement: Must check first box and at least one other box.

- ☐ Mobilize 3 times a day and/or as directed (walking, unless bed or chair-bound or otherwise directed to promote the highest practicable level of mobility)
- ☐ Out of bed or leave room for meals
- ☐ Physical therapy (PT) intervention (balance, gait, strength, gate training, exercise program)
- ☐ Avoid restraints (physical and chemical)
- ☐ Remove catheters and other tethering devices
- ☐ Avoid high-risk medications
- ☐ Other ____

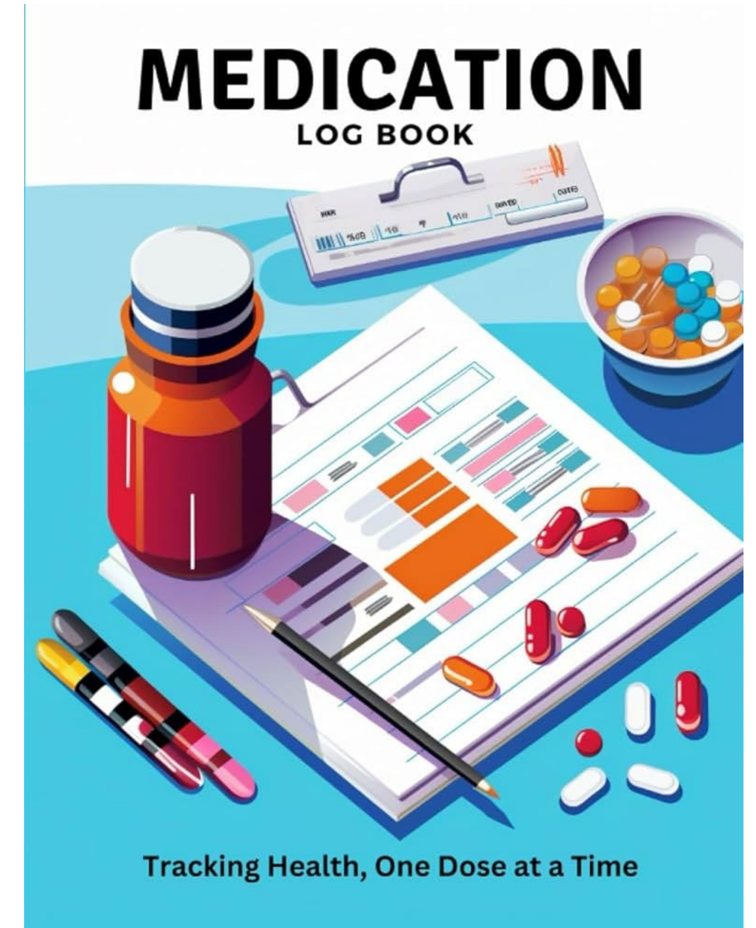
**Primary Responsibility:**
Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ MD / PA / Nurse Practitioner
- ☐ Physical Therapist / Occupational Therapist
- ☐ Other ____

# Assessment of Medications in use

**Screen / Assess:**
Check the medications you screen for in all older adults.
Minimum requirement: All eight boxes must be checked.

- ☐ Benzodiazepines, Anxiolytics
- ☐ Opioids
- ☐ Highly-anticholinergic medications (e.g., diphenhydramine)
- ☐ All prescription and over-the-counter sedatives and sleep medications (hypnotics)
- ☐ Muscle relaxants
- ☐ Tricyclic or other antidepressants
- ☐ Antipsychotics
- ☐ Mood Stabilizers
- ☐ Other




# MDS- Section N

# Screening and Assessment of Cognitive Impairment

**Screen:**
Check the tool used to screen for Cognitive Impairment for all older adults.
Minimum requirement: At least first box must be checked. If only "Other" is checked, will review.

- ☐ Mini-Cog
- ☐ BIMS (included in MDS)
- ☐ Other __________

**Assess:**
Check the tool used to assess for Cognitive Impairment.
Minimum requirement: If screen is positive, conduct assessment. If only "Other" is checked, will review

- ☐ SLUMS
- ☐ MOCA
- ☐ Other __________

# MDS- Section C0200-C0500 & C0600-C1000

OkDCN Oklahoma Dementia Care Network

# Screening and Assessment of Depression

**Screen / Assess:**

Check the tool used to screen for depression for all older adults.

Minimum requirement: At least one of the first four boxes must be checked. If only "Other" is checked, will review

- ☐ Patient Health Questionnaire (PHQ)-2
- ☐ Patient Health Questionnaire (PHQ)-9
- ☐ Geriatric Depression Scale (GDS) - short form
- ☐ Geriatric Depression Scale (GDS)
- ☐ Other

MDS- Section D0100-C0160 & C0500-C0600

# Screening and Assessment of Delirium

**Screen / Asses:**

Check the tool used to screen for delirium for all older adults.

Minimum requirement: At least one must be checked. If "other" is checked, will review.

- ☐ UB-CAM
- ☐ CAM (Included in MDS)
- ☐ Other

## MDS- Section C1310

# Screening and Assessment of Mobility

**Screen / Assess:**

Check the tool used to screen for mobility limitations for all older adults.

Minimum requirement: One box must be checked. If screening/assessment is done by physical therapy, please identify the tool used. If only "Other" is checked, will review.

- ☐ Timed Up & Go (TUG)
- ☐ Johns Hopkins High Level of Mobility (JH-HLM)
- ☐ Tinetti Performance Oriented Mobility Assessment (POMA)
- ☐ Screening and assessment forms per physical therapy ____________
- ☐ Other ____________

## MDS- Section GG0170

# Frequency of Assessment

**Frequency:**

Minimum frequency is upon admission and upon change of condition.

- ☐ At admission
- ☐ Upon change of condition
- ☐ Other

# Documentation

**Documentation:**

Minimum requirement: Must check Care Plan.

- ☐ EHR
- ☐ Care Plan
- ☐ Other ____________________

# Act On Mobility

**Act On:**

Minimum requirement: Must check first box and at least one other box.

- ☐ Mobilize 3 times a day and/or as directed (walking, unless bed or chair-bound or otherwise directed to promote the highest practicable level of mobility)
- ☐ Out of bed or leave room for meals
- ☐ Physical therapy (PT) intervention (balance, gait, strength, gate training, exercise program)
- ☐ Avoid restraints (physical and chemical)
- ☐ Remove catheters and other tethering devices
- ☐ Avoid high-risk medications
- ☐ Other

# Primary Responsibility for Assessing/Documenting and Acting On Mobility Concerns

**Primary Responsibility:**

Minimum requirement: One role must be selected.

- ☐ Nurse
- ☐ MD / PA / Nurse Practitioner
- ☐ Physical Therapist / Occupational Therapist
- ☐ Other ____________________

# Facility Level Report for your 4M data – Resident Impact Report

iQIES Report

MDS 3.0 Facility-Level Quality Measure (QM) Report

MDS Measures

| Measure Description | CMS ID | Data | Num | Denom | Facility Observed Percent | Facility Adjusted Percent | Comparison Group State Average | Comparison Group National Average | Comparison Group National Percentile |
|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers (L) | N045.01 | I | 0 | 26 | 0.0% | 0.0% | - | - | 0 |
| Phys restraints (L) | N027.02 | C | 0 | 28 | 0.0% | 0.0% | 0.2% | 0.1% | 0 |
| Falls (L) | N032.02 | C | 12 | 28 | 42.9% | 42.9% | 50.0% | 43.8% | 44 |
| Falls w/Maj Injury (L) | N013.02 | C | 1 | 28 | 3.6% | 3.6% | 4.8% | 3.5% | 58 |
| Antipsych Med (S) | N011.03 | C | 0 | 12 | 0.0% | 0.0% | 2.5% | 1.9% | 0 |
| Antipsych Med (L) | N031.04 | C | 2 | 25 | 8.0% | 8.0% | 15.9% | 14.9% | 26 |
| Antianxiety/Hypnotic Prev (L) | N033.03 | C | 1 | 17 | 5.9% | 5.9% | 11.9% | 7.4% | 53 |
| Antianxiety/Hypnotic % (L) | N036.03 | C | 3 | 23 | 13.0% | 13.0% | 25.9% | 20.0% | 27 |
| Behav Sx affect Others (L) | N034.02 | C | 5 | 27 | 18.5% | 18.5% | 16.8% | 18.5% | 60 |
| Depress Sx (L) | N030.03 | C | 0 | 27 | 0.0% | 0.0% | 3.6% | 8.9% | 0 |
| UTI (L) | N024.02 | C | 1 | 28 | 3.6% | 3.6% | 3.5% | 2.2% | 78* |
| Cath Insert/Left Bladder (L) | N026.03 | C | 0 | 27 | 0.0% | 0.0% | 2.3% | 1.5% | 0 |
| New or Worsened B/B (L) | N046.01 | I | 1 | 1 | 100.0% | 100.0% | - | - | - |
| Excess Wt Loss (L) | N029.03 | C | 0 | 23 | 0.0% | 0.0% | 4.9% | 6.4% | 0 |
| Incr ADL Help (L) | N028.03 | C | 0 | 1 | 0.0% | 0.0% | 13.8% | 16.3% | 0 |
| Move Indep Worsens (L) | N035.04 | C | 0 | 1 | 0.0% | 0.0% | 31.0% | 30.4% | 0 |

# Quality Measures- What Matters Most, Medications, Mentation & Mobility

| 4Ms | CMS LTC Quality Measures Mapped to 4Ms of Age-Friendly and Dementia-Friendly Care |
|---|---|
| **What Matters Most** | % of residents whose need for help with ADLs increased<br>% of residents who lose too much weight<br>% of low-risk residents who lose control of their bowels or bladder<br>% of residents with who have had a catheter inserted and left in bladder<br>% of residents with a urinary tract infection |
| **Medications** | % residents who received an antipsychotic medication<br>% of residents who used antianxiety or hypnotic medication |
| **Mentation** | % of residents with behavioral symptoms affecting others<br>% of residents who have symptoms of depression |
| **Mobility** | % of residents experiencing one or more falls with major injury<br>% of residents whose ability to move independently worsened<br>% of residents who were physically restrained<br>% of high-risk residents with pressure injuries |

# What Matters Most Impact

**Changes made:**

- Asking new resident-centric questions about their care and living preferences upon admission and at regular intervals throughout their stay.
- Focused on reducing the number of residents needing help with ADLs

**Impact:** Asking about what matters most to the resident and including family members in the discussion builds trust between the resident, family, and staff  and helps residents better adjust to their new home.

# Medication Impact

## Changes made:

- Comprehensive medication review and using evidenced-based tapering regimens to reduce the use of high-risk medications.
- Focused primarily on reducing antipsychotic medication use.

## Impact:

Reducing the use of high-risk medications had a positive impact on other aspects of 4Ms care. For example, the reduction and eventual elimination of a resident's antipsychotic medication resulted in fewer daytime naps, increased participation in activities, and greater socialization, bringing him more connection and joy—meeting what mattered most to him and his family. He also ambulated more freely, had clearer thinking and improved mood, and stopped losing weight. A family saying, "*Thank you for bringing my loved one back*," is one of the biggest compliments a nursing home can receive.

## Mentation Impact

**Changes made:**

- Tailoring activities to include residents with decreased cognitive function to increase engagement.
- Focused on reducing dementia-related behaviors affecting others.

**Impact:** Nursing leadership modeled this culture change to better adapt care practices and group activities to engage persons with cognitive impairment. As the Director of Nursing stated, "*We are ALL family here*." This culture change included better identification of residents with cognitive impairment and mental health care needs, as well as focusing on caring compassionately and being a family. The nursing homes used the Brief Interview for Mental Status (BIMS) and the Patient Health Questionnaire 9 (PHQ-9) as screening tools for cognitive impairment and depression, respectively.
Changed from DON
Added: Spelled out BIMS and PHQ-9

# Mobility Impact

- **Changes made:**
- Focused on reducing falls with major injuries.
- Having a team huddle (Q&A session), conducting a root cause analysis, and planned intervention for each fall.
- Involving restorative aides immediately after a fall to help prevent future falls.
- Indicating  the  mode of resident transfer on all care plans.
- Walking rounds every morning by the Administrator.
- Including more range of motion, fall prevention, and mobility exercises (by Activity Director) in group activities to promote safe, stable  mobility.
- Regularly conducting medication reviews to identify medications that may be hindering stable mobility.

**Impact** : Both facilities have had small reductions in falls with major injuries and have changed staff culture around best practices for promoting mobility and fall prevention.

- Changed from: Getting restorative aides involved immediately.
- Changed from Indicate
- Administrator does walking rounds every morning.
- Changed from: Activity Director is including more range of motion, fall prevention, and mobility exercises in group activities to promote safe, stable mobility.
- Changed from: Regular medication review for medications that may be hindering mobility.

## Steps to Achieve IHI Recognition

Fill out 4Ms Care Description Worksheet at

https://www.ihi.org/initiatives/age-friendly-health-systems/recognition

Email Completed worksheet: AFHS@ihi.org

Implement plan for achieving the next level of Committed to Care Excellence recognition

# Dawn Jelinek
## Age-Friendly Clinics and LTC

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