Spreading the 4Ms and Becoming an Age-Friendly Health System Practice

Background

UNC Geriatrics Clinic is a primary care practice located at 100 Eastowne Drive in Chapel Hill, North Carolina. We serve the state, and most of the patients come from the greater Triangle area. Our clinic primarily serves older adults, 65 and above, with a patient-centered approach to care. However, we also see some patients under 65 who are experiencing chronic conditions commonly experienced by a geriatric population such as falls, dementia, and incontinence. Our mission is to help patients meet their personal health goals and walk with them through all stages of later life.

Based on data from September 7, 2021, we see a total of 3,217 patients. Of these patients, 65% are female and 35% are male; we also have 38 patients who do not have gender information in our system which accounts for discrepancies between the total number of patients and the sum of our female and male patients (Figure 1). Ninety four percent of our patient population is above the age of 65.

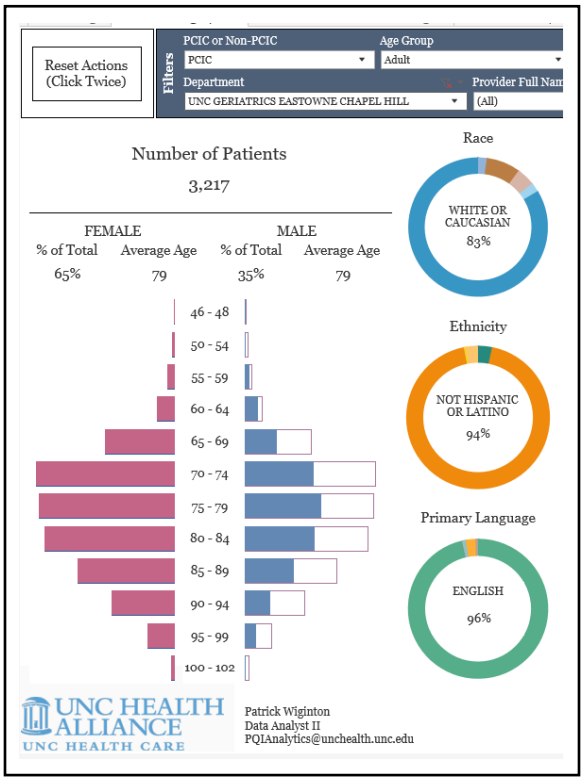

Figure 1. UNC Geriatrics Clinic at Eastowne patient demographics overview

Physicians at our clinic are certified in both Internal or Family medicine and Geriatrics, meaning that our providers can meet both patients' primary care and aging-related needs. In addition, our team includes two geriatric nurse practitioners, a neurologist, a geriatric psychiatrist, and a geriatric pharmacist who all have geriatric expertise. On the population health side, we have a geriatrics social worker and a population health specialist who assist patients with care management and resource coordination.

We are a teaching clinic and train 3-4 new Geriatric Medicine Fellows a year in dementia care, advance care planning, gait assessment, and polypharmacy. These fellows work closely with our attending physicians and the geriatric pharmacist while managing their own patient panel.

Prior to the COVID-19 pandemic, the UNC Geriatrics Clinic became certified as a Level 1 Age-Friendly Health System (AFHS) in March 2020. The UNC Geriatrics Clinic became an AFHS due to the importance of the 4Ms as part of evidence-based care for older adults and to represent the clinic's commitment to quality care. Unfortunately, due to the pandemic, our efforts to become recognized as a Level 2 AFHS were interrupted. Currently, we are working towards Level 2 AFHS certification, which includes conducting patient observation and chart review to audit our clinic's practice of the 4Ms.

Approach

The UNC Geriatrics Clinic is using an Americorps MedServe Fellow to observe the 4Ms in action. MedServe Fellows are recent college graduates who have completed a pre-medical curriculum and are taking time off before applying to medical school. MedServe Fellows are bright, service-minded, and eager to learn. MedServe Fellows undergo a rigorous two-week Training Institute to prepare for their roles.

In addition, Americorps hosts quarterly skill summits across the state to expose students to key medical concepts and help them prepare for the next stage of their medical education. As a geriatrics clinic, we currently practice many components of the 4Ms. We have outlined how each of the 4Ms are addressed during a clinical visit in the following sections.

Mentation

Our care partners (CMAs, LPNs, RNs) conduct annual depression screenings (PHQ-2 and/or PHQ-9) during their triage process. Once the screening has been completed, a provider (physician, nurse practitioner or physician assistant) must approve the addition of the results in the electronic medical record (EMR). In situations where patients have higher mental health needs, their provider may refer them to our geropsychiatrist.

Dementia is addressed in clinic by the provider and can include assessments such as the Mini-Mental State Examination (MMSE), the Saint Louis University Mental Status (SLUMS) examination, and the Montreal Cognitive Assessment (MoCA). Similar to mental health needs, if providers identify a greater need for support with dementia patients, they may send a referral to our neurologist and/or to our geropsychiatrist.

Mobility

Mobility is primarily addressed through fall assessments and gait assessments. Falls are assessed annually with a two-part questionnaire by the care partner during triage. When medically indicated, providers will conduct a diagnostic gait evaluation. These evaluations are used to determine if patients are exhibiting common patterns of gait abnormalities, such as those associated with peripheral neuropathy or Parkinson ’s disease. If mobility needs are identified, providers may refer patients to physical therapy or request durable medical equipment (DME) to help patients meet their ambulatory goals. These referrals are typically facilitated by our social worker and population health specialist.

Medication

Medication reconciliation is typically conducted at the beginning of every visit during the triage process. Our care partners review the patient’s medication list in our EMR with the patient and/or their caregiver and adjust the chart to reflect any changes in medication use. Our geriatric pharmacist also conducts more detailed medication reconciliations for complex cases, when needed. In addition to regular medication reconciliations, our clinic has an overarching focus on de-prescribing medications that are inconsistent with mobility and mentation goals for older adults, such as benzodiazepines and anticholinergic medications.

What matters

Historically, discussions of what matters have been provider-driven, but they are discussions about the patient's priorities and their future direction of care. The provider driven conversations often focus on assigning a Health Care Power of Attorney (HCPOA), completing a Living Will, Medical Orders for Scope of Treatment (MOST) and Do Not Resuscitate (DNR) forms.

What We Found: Outcomes

Clinic observations of 10 patients conducted by the MedServe Fellow showed that the 4Ms are conducted 88% of time.

Table 1. 10-patient audit of the 4Ms. Patients were observed throughout their visit.

Patient Count	Mentation	Mobility	Medications	What Matters
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	✓
4	✓		✓	
5	✓	✓		✓
6	✓	✓	✓	✓
7	✓		✓	✓
8	✓	✓	✓	✓
9	✓		✓	✓
10		✓	✓	✓

Table 1 summarizes the results of 10 real-time patient observations conducted by the MedServe Fellow at our clinic. During these observations, the patient was followed for the entirety of their visit, beginning with triage and ending with the check-out process. Notes were collected during the visit, specifically focusing the on 4Ms. Chart review was also used to supplement the patient observations.

For example, if a MMSE, SLUMS, or MoCA was not conducted during the visit but a provider at our clinic had previously documented such an assessment in the EMR, it was counted as fulfilling the Dementia category of the 4Ms. In addition, for What Matters, conversations that centered around what patients hoped to gain from their care and their priorities were counted in addition to more formal conversations about advance care planning.

How We Spread the 4Ms and Became an Age-Friendly Health System Practice

UNC Geriatrics Clinic has engaged with the community in a variety of ways, including collaboration with caregiver support programs and organizations that provide home-based services for geriatric patients. Our social worker often refers patients to the Duke Dementia Family Support Program and the Dementia Alliance when patients and caregivers are struggling with mentation-related issues. In addition, UNC Geriatrics Clinic has partnered with Premier Home Health Care Services and Elderfit In Home Rehab.

Both organizations provide home-based care, allowing our patients to stay in their homes for as long as safely possible. For many of our patients, being able to stay at home is one of their main priorities and having home care or in-home physical therapy services (Elderfit) can help them with these goals.

Lessons Learned

Having a MedServ Fellow championing the 4Ms and using observation has embedded AFHS care in our culture and daily workflow. One of the primary challenges we have encountered in attaining Level 2 certification as an AFHS has been the COVID-19 pandemic. In 2020, we had to suspend our efforts to reach Level 2 certification as our clinic shifted primarily to telehealth.

The transition to telehealth initially led to some barriers to patient care as the clinic tried to adjust to new modes of communication. In addition, teaching our patients and their caregivers how to use new technology was difficult, especially given our geriatric patient population. Recently, we reinitiated our efforts to attain Level 2 AFHS certification but the hiatus due to the pandemic has certainly been a challenge.

Given that we are a geriatrics clinic, we have a unique perspective on the journey towards AFHS certification. Many of the 4Ms were already addressed by providers long before the AFHS certification. However, the model has provided us with new opportunities to reassess our workflow and identify areas for improvement and refinement. We hope that the AFHS model can make its way to many other clinics and increase awareness and focus on the specific needs of geriatric patients.

About the Authors

Written by Nina Raymo, BS, MedServe Fellow, UNC Geriatrics
Edited by Jennifer Hubbard, BA and Meredith Gilliam, MD, MPH