Age-Friendly Health Systems

4Ms Age-Friendly Care Description Worksheet
Ambulatory Care Setting

Overview

This document is a Word version of the "4Ms Care Description" electric form. This document is a tool for teams to draft their descriptions before their final submissions, here. The completion of this survey is required to be recognized by IHI's Age-Friendly Health Systems. For any questions, please email AFHS@ihi.org.

Please describe below your description of age-friendly (or 4Ms) care as your team currently operationalizes it. To be considered age-friendly, you must explicitly engage or screen/assess people ages 65 and older for all 4Ms (What Matters, Medication, Mentation, Mobility), document 4Ms information, and act on the 4Ms accordingly.

Date:

Health System Name:

Hospital or Clinic Name (If you have multiple practices, please list each practice.):

Location (City, State):

Key Contact (Name, Email):

EHR Platform:

	What Matters	Medication	Mentation: Dementia	Mentation: Depression	Mobility
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	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	Prevent, identify, treat, and manage dementia across settings of care	Prevent, identify, treat, and manage depression across settings of care	Ensure that each older adult moves safely every day to maintain function and do What Matters most
Engage / Screen / Assess Please check the boxes to indicate items used in your care or fill in the blanks if you check "Other."	List the question(s) you ask to know and align care with each older adult's specific outcome goals and care preferences: _One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life forms._	Check the medications you screen for regularly: ☐Benzodiazepines ☐Opioids ☐Highly-anticholinergic medications (e.g., diphenhydramine) ☐All prescription and over-the-counter sedatives and sleep medications ☐Muscle relaxants ☐Tricyclic antidepressants ☐Antipsychotics ☐Other:_____ _Minimum requirement: At least one of the first seven boxes must be checked._	Check the tool used to screen for dementia: ☐Mini-Cog ☐SLUMS ☐MOCA ☐Other:_____ _Minimum requirement: At least one of the first three boxes must be checked. If only "Other" is checked, will review._	Check the tool used to screen for depression: ☐PHQ-2 ☐PHQ-9 ☐GDS – short form ☐GDS ☐Other:_____ _Minimum requirement: At least one of the first four boxes must be checked. If only "Other" is checked, will review._	Check the tool used to screen for mobility limitations: ☐TUG ☐Get Up and Go ☐ JH-HLM ☐ POMA ☐ Refer to PT ☐Other:_____ _Minimum requirement: One box must be checked. If only "Other" is checked, will review._

Optional: Check the tool used for functional assessment:
☐ Barthel Index of ADLs (in EPIC)
☐ Lawton IADLs
☐ Katz ADL
☐Other:_____
Optional to select.

	What Matters	Medication	Mentation: Dementia	Mentation: Depression	Mobility
Frequency	☐Annually ☐ Every visit ☐Other: _____ *Minimum frequency is annually.*	☐Annually ☐At change of medication ☐ Every visit ☐Other: _____ *Minimum frequency is annually.*	☐Annually ☐ Every visit ☐Other: _____ *Minimum frequency is annually.*	☐Annually ☐ Every visit ☐Other: _____ *Minimum frequency is annually.*	☐Annually ☐ Every visit ☐Other: _____ *Minimum frequency is annually.*
Documentation Please check the "EHR" box (for electronic health record) or fill in the blanks for "Other."	☐EHR ☐Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method is accessible to other care team members for use during care.*	☐EHR ☐Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method is accessible to other care team members for use during care.*	☐EHR ☐Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method can capture assessment to trigger appropriate action.*	☐EHR ☐Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method can capture assessment to trigger appropriate action.*	☐EHR ☐Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method can capture mobility status in a way that other care team members can use.*
Act On Please describe how you use the information obtained from Engage/Screen/Assess to design and provide care. Refer to pathways or procedures that are meaningful to your staff in the "Other" field.	☐Align the care plan with What Matters most ☐Other: _____ *Minimum requirement: First box must be checked.*	☐Educate older adult and family caregivers ☐ Deprescribe (includes both dose reduction and medication discontinuation) ☐Refer to: _____ ☐Other: _____	☐Share results with older adult ☐Provide educational materials to older adult and family caregivers ☐Refer to community organization for education and/or support	☐Educate older adult and family caregivers ☐Prescribe anti-depressant ☐Refer to: _____ ☐Other: _____ *Minimum requirement: At least one of the first three boxes must be checked.*	☐ Multifactorial fall prevention protocol (e.g., STEADI) ☐Educate older adult and family caregivers ☐ Manage impairments that reduce mobility (e.g., pain, balance, gait, strength)

	What Matters	Medication	Mentation: Dementia	Mentation: Depression	Mobility
		Minimum requirement: At least one box must be checked.	☐ Refer to: _____ ☐ Other: _____ Minimum requirement: Must check first box and at least one other box.		☐ Ensure safe home environment for mobility ☐ Identify and set a daily mobility goal with older adult that supports What Matters, and then review and support progress toward the mobility goal ☐ Avoid high-risk medications ☐ Refer to physical therapy ☐ Other: _____ Minimum requirement: Must check the first box or at least 3 of the remaining boxes.
Primary Responsibility Indicate which care team member has primary responsibility for the older adult.	☐ Nurse ☐ Clinical Assistant ☐ Social Worker ☐ MD ☐ Pharmacist ☐ Other: _____ Minimum requirement: One role must be selected.	☐ Nurse ☐ Clinical Assistant ☐ Social Worker ☐ MD ☐ Pharmacist ☐ Other: _____ Minimum requirement: One role must be selected.	☐ Nurse ☐ Clinical Assistant ☐ Social Worker ☐ MD ☐ Pharmacist ☐ Other: _____ Minimum requirement: One role must be selected.	☐ Nurse ☐ Clinical Assistant ☐ Social Worker ☐ MD ☐ Pharmacist ☐ Other: _____ Minimum requirement: One role must be selected.	☐ Nurse ☐ Clinical Assistant ☐ Social Worker ☐ MD ☐ Pharmacist ☐ Other: _____ Minimum requirement: One role must be selected.