Dartmouth Centers for Health & Aging

Introducing The 4Ms Framework for an Age-Friendly Health System

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Disclosures

- I have no financial conflicts of interest to disclose

Learning Objectives

1. Summarize the 4Ms of an Age-Friendly Health System.
2. Explain what an Action Community is.
3. Recall Northern New England Geriatric Workforce Enhancement Program's role in the Action Community.
4. Identify how can you use billable Medicare visits to help achieve status as an Age-Friendly Health System.

Agenda

- Introduction to an Age-Friendly Health System and the 4Ms
- Introduction to Age-Friendly Health System Action Community
- Implementing an Age-Friendly Health System using Medicare Codes
- Geriatric Interprofessional Team Transformation – Primary Care's Opportunity

Age-Friendly Health System

An Age-Friendly Health System (AFHS) is an initiative of:

- The John A. Hartford Foundation
- Institute for Healthcare Improvement (IHI)
- In partnership with the:
  - American Hospital Association
  - Catholic Health Association of the United States

Source: https://www.johnahartford.org/age-friendly-health-systems-initiative

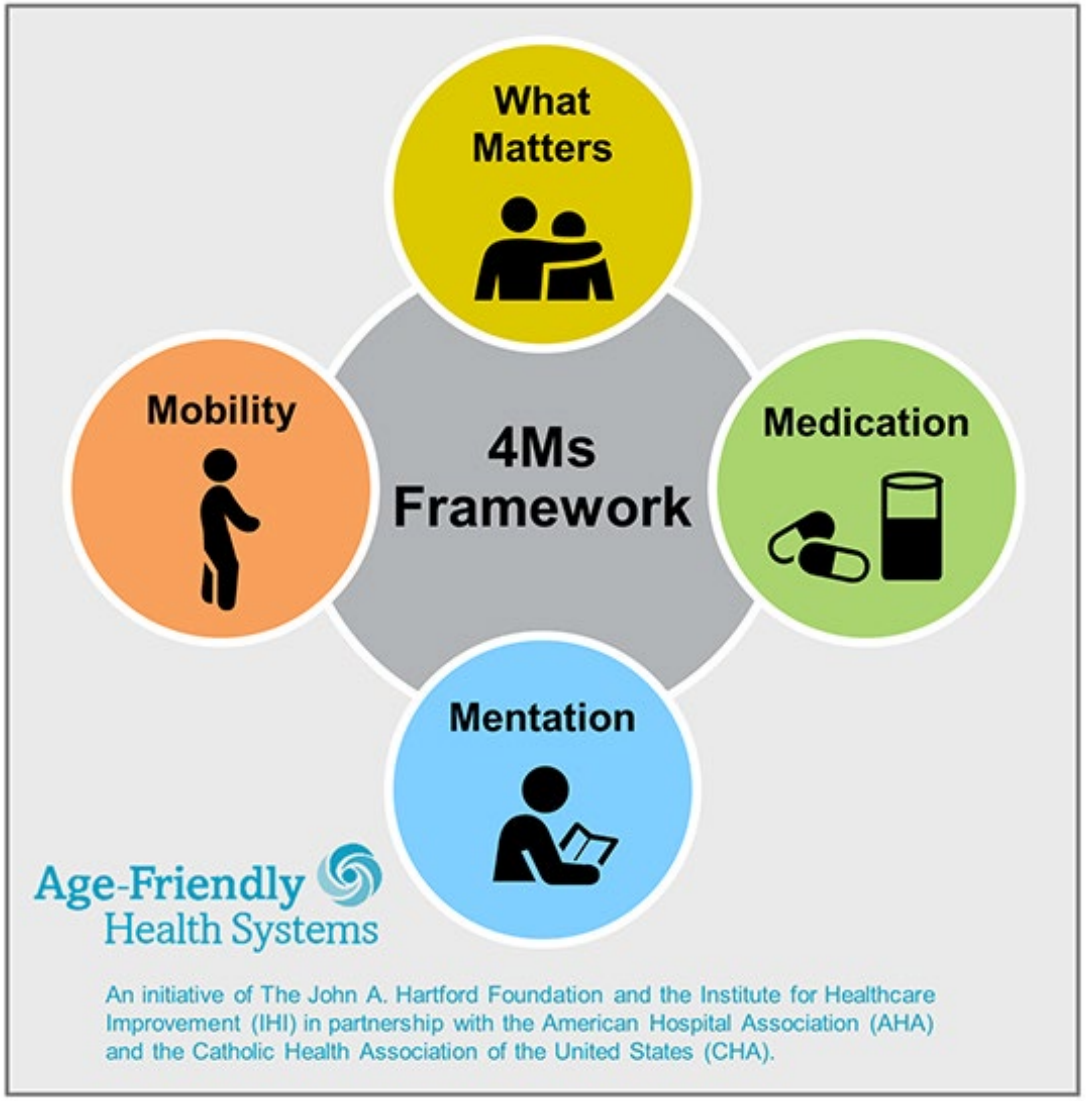
Age-Friendly Health System

- An Age-Friendly Health System is one in which every older adult:
  - Gets the best care possible;
  - Experiences no health care-related harms; and
  - Is satisfied with the health care they receive.
- In an Age-Friendly Health System, value is optimized for all — patients, families, caregivers, health care providers, and the overall system.

Source: https://www.johnahartford.org/age-friendly-health-systems-initiative

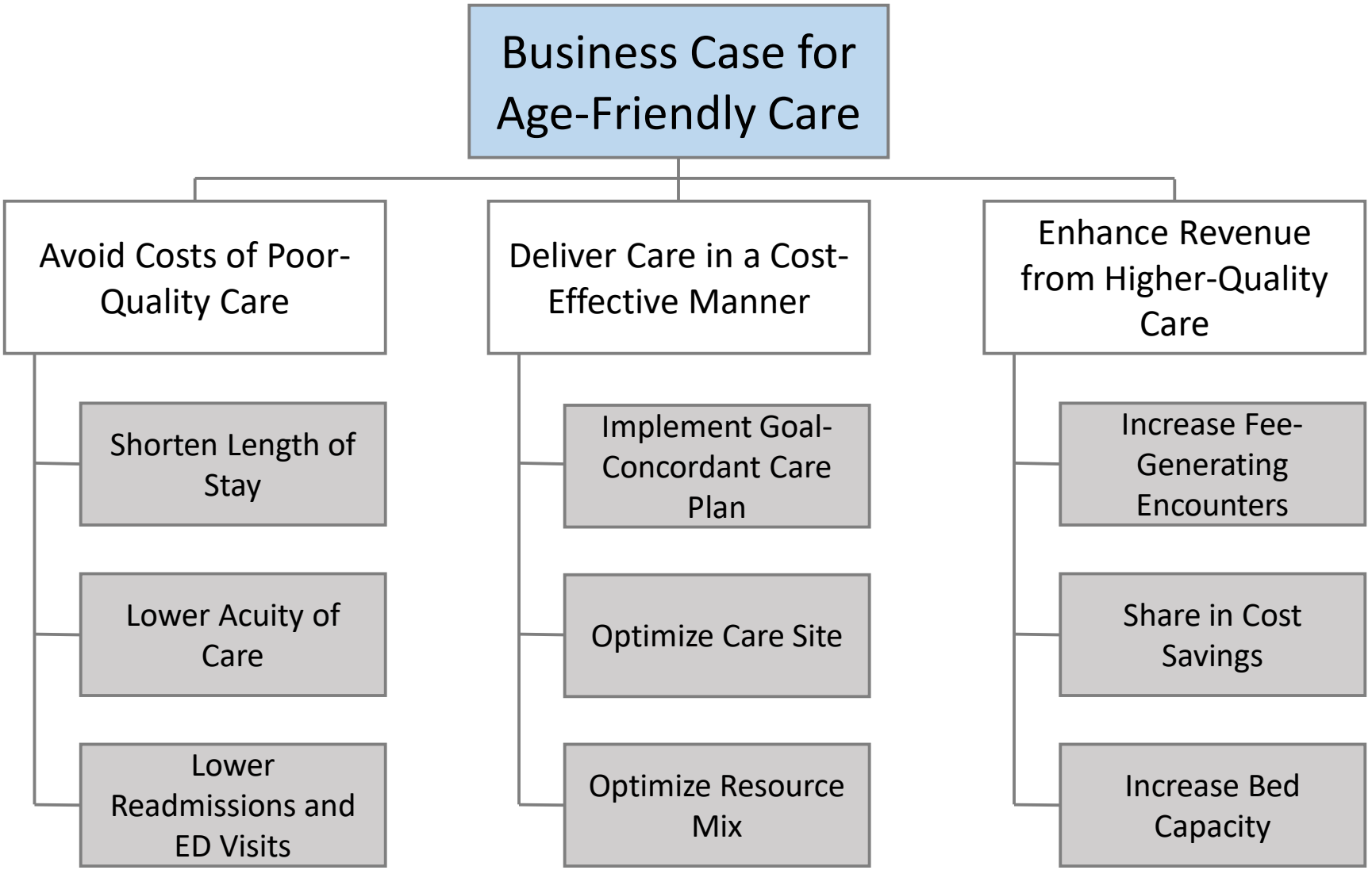
What Does it Mean to Be Age-Friendly?

You do these 4 things (4Ms) together:



Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Business Case for Age-Friendly Care



Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Business_Case_for_Becoming_Age_Friendly_Health_System.pdf

Business Case – Outpatient Setting

Case Study (St. Vincent Medical Group, Indianapolis, Indiana)

- Financial returns from Annual Wellness Visit
  - Net income
  - Subsequent income-generating encounters the AWV drives
  - Improved quality scores in value-based reimbursement programs
- Net Income from the Advance Care Plan
- Net Income from Preventive Screening

Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Business_Case_for_Becoming_Age_Friendly_Health_System.pdf

Two Levels of Recognition by IHI

1. An AFHS Participant
   - "being on the journey"
   - Submitted a description on how it is working towards putting the 4Ms into practice
2. An AFHS Committed to Care Excellence
   - "being an exemplar"
   - 3-months' count of older adults reached with evidence-based, 4M care

Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/Age-Friendly%20Health%20Systems%20Recognition%20Frequently%20Asked%20Questions.pdf

Action Communities

- Teams engaged in an Age-Friendly Health System Action Community:
- Test the 4Ms Framework in their hospital or ambulatory care setting
- Participated in a 7-month virtual learning community to help accelerate their work
- Shared data and learnings

Source: https://www.johnahartford.org/age-friendly-health-systems-initiative

GWEPs

- Geriatric Workforce Enhancement Program (GWEP)
- Federally funded grants support by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS)
  - 48 GWEP programs across 35 states and 2 territories (Guam and Puerto Rico)
  - Improve health outcomes for older adults
  - Develop a healthcare workforce that maximizes patient and family engagement
  - Integrating geriatrics and primary care

GWEP Notice of Funding Opportunity

- Promote Age-Friendly Health Systems
- MIPS measures related to AFHS
  - Dementia caregiver education and support
  - Care plan
  - High-risk medications in the elderly
  - Falls

GWEP Coordinating Center

- Supports GWEPs
- Bringing them together for national meetings
- Providing resources to be used towards products, memberships, meeting travel, and offering other educational and networking opportunities, such as webinars and advocacy training

Source: https://www.americangeriatrics.org/programs/gwep-coordinating-center

The 4Ms

- 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.

Source: www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

The 4Ms

- Mentation
  - Prevent, identify, treat, and manage delirium across settings of care.
- Mobility
  - Ensure that each older adult moves safely every day to maintain function and do What Matters.

Source: www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Putting the 4Ms into Practice

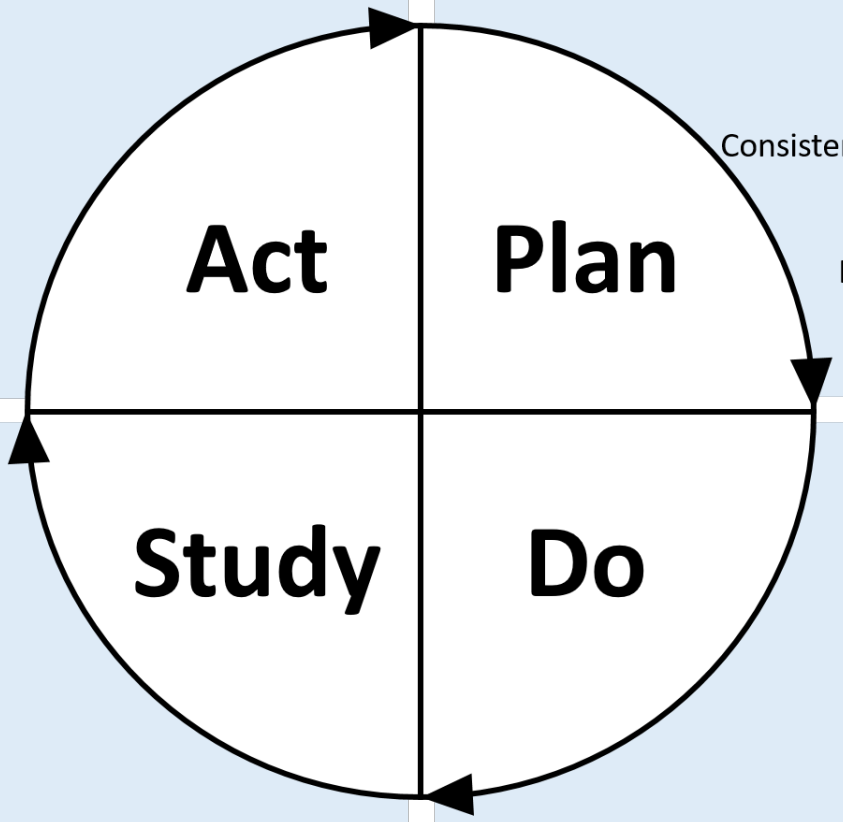
Steps for integrating the 4Ms into your standard care:

1. Understand Your Current State
2. Describe Care Consistent with the 4Ms
3. Describe or Adapt Your Workflow
4. Provide Care
5. Study Your Performance
6. Improve and Sustain Care

* You can approach steps 2 through 6 as a loop aligned with the Plan-Do-Study-Act (PDSA) cycles.

Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

- **Step 1**
  Understanding your current state



- **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

Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

Northern New England GWEP

Northern New England GWEP's training program, Geriatric Interprofessional Team Transformation - Primary Care (GITT-PC), helps primary care teams use their unique skill sets to achieve the quadruple aim:

- Improve patient outcomes
- Enhance patient experience
- Improve staff satisfaction
- Reduce costs, increase revenue, increase relative value units

How GITT-PC Does It

- Practice assessment
- Content training and supporting materials
- Focus on teams
- Learning collaborative
- Pre-post measures

GITT-PC and the 4Ms

GITT-PC helps teams implement the 4Ms of an Age-Friendly Health Systems through the use of four Medicare reimbursable codes:

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Advance Care Planning (ACP)
- Medicare Annual Wellness Visit (AWV)

Transitional Care Management

Description

- Services during transition to community following particular kinds of discharge
- Taking responsibility for the patient's care without a gap
- 30-day period

TCM Moderate Complexity
- **99496** – NFP $235; RVU 3.05

TCM High Complexity
- **99495** – NFP $167; RVU 2.11

Components

- Interactive contact within 2 business days
- Certain non-face-to-face services
  - Review discharge
  - Need follow-up test/treatments
  - Interact with health care specialists
  - Educate on self management, independent living, & ADLs
  - Needed community services
  - Referral to community providers
  - Adherence to treatments & medication management
- Face-to-face visit within 7-14 days

Workforce

- Schedulers
- Clinical staff
- Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Chronic Care Management

Description

- Monthly care management
- For patients with increase risk of death, acute exacerbation, decompensation, or functional decline
- Concurrent monthly billing
- Part B cost sharing applies

CCM
- **99490** (20') – NFP $42 RVU 0.61
- **99491** (30') – NFP $84; RVU 1.45

Complex CCM
- **99487** (60') – NFP $93; RVU 1.00
- **99489** (add'l 30') – NFP $46; RVU 0.50

Components

- Initiating visit within 1 year
- Patient consent
- 2 or more chronic conditions
- Comprehensive care plan
- Provide 24/7 access to physician / non-physician practitioner
- Manage transitions between and among health care providers
- At least 20 minutes care management per month

Workforce

- Clinical staff (can contribute to time)
- Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Advance Care Planning

Description

- Voluntary discussion of health care wishes
- No limits on number of times you can report
- Covered in Medicare Annual Wellness Visit
- Outside of Medicare Annual Wellness Visit, Part B cost sharing applies
- No place-of-service limitations

- **99497** (30') – NFP $86; RVU 1.50
- **99498** (add'l 30') – NFP $76; RVU 1.40

Components

- Face-to-face service
- Discussion about advance care planning (the type of care the patient gets and where and when they get it)
- Discussion about advance directives with/without completion of forms
- Discussion with the patient, family member(s), and/or surrogate

Workforce

- Clinical staff (can contribute to time)
- Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdfSource: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Annual Wellness Visit (AWV)

Description

- Medicare Part B
- Free yearly visit
- Health promotion and disease detection
- Not a hands-on exam
- Does not address new or existing chronic medical conditions

- **G0438** – NFP $174; RVU 2.43
- **G0439** – NFP $118; RVU 1.50

Components

- Health Risk Assessment
- Medical & family history
- Medication review including high risk and opioid use
- Providers & suppliers
- Height, weight, Body Mass Index, blood pressure
- Cognitive assessment
- Depression assessment
- Level of safety/falls assessment
- Screening schedule
- Risk factors
- Personalized health advice
- Advance care planning

Workforce

- Schedulers / exit secretaries
- Rooming staff
- Nursing (can bill incident-to)
- Physician / non-physician practitioner

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Referrals to the Community

Referral to Aging Resource Center — ✓Accept | ✕Cancel

Class	Internal Ref	Internal Referral	External Referral	
Referral	By Provider:	Moran, Daniel S [1278]		
	To Department:	ARC Shared Decision	ARC Shared Decision	
	To Provider:			
	Reason:	Specialty Services	Specialty Services Requested	
	Priority:	Routine	Routine	Urgent
	# of visits:	1		

Service Requested

☐ Caregiver Support ☐ Dementia/Memory – Support ☐ Dementia/Memory – Education ☐ Memory Cafe
☐ Hoarding Resources ☐ Spiritual Care ☐ Bereavement ☐ Advance Care Planning **☒ Falls Prevention**
☐ Parkinson's Resources

Process Inst.: If no progress note charted, please enter Clinical details in comments.

Referral: + Add Comments (F6)

Show Additional Order Details

Next Required — ✓Accept | ✕Cancel

Summary

- An Age-Friendly Health System is an initiative to implement the 4Ms (What Matters, Medications, Mentation, and Mobility) to help older adults get the best possible care.
- Action Communities are a 7-month virtual learning community to help teams accelerate their work towards meeting the 4Ms of an AFHS.
- The Northern New England GWEP is providing leadership in conjunction with GWEP-CC around AFHS.
- Medicare AWV, TCM, CCM, and ACP are Medicare reimbursable codes that can help teams achieve status as an Age-Friendly Health System.