

# AGE-FRIENDLY CLINICAL CARE: the 4Ms and what Matters most

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COUNTY OF SAN DIEGO  
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[SANDIEGOCOUNTY.GOV](http://SANDIEGOCOUNTY.GOV)



# WHAT IS A GERIATRICIAN



Board Certified Internal Medicine  
Physician  
+  
Board Certification in Geriatrics  
+  
Holistic approach (what matters)  
+  
F Word

# FUNCTION- ACTIVITIES OF DAILY LIVING

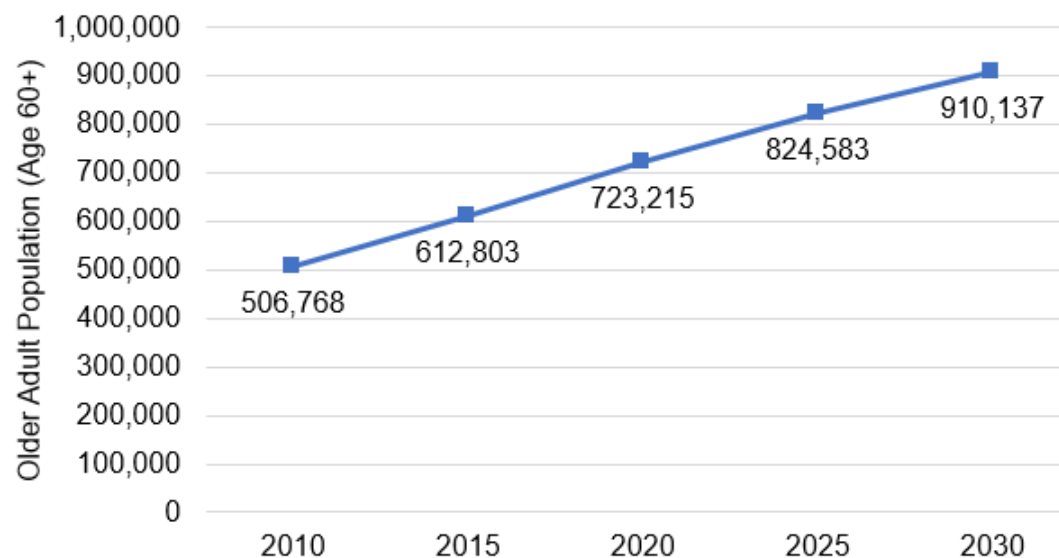


Basic		
		<p>(Muñoz-Neira et al., 2012; Slachevsky et al., 2019)</p>

# CONTEXT: AGING POPULATION



Growth in the Older Adult Population (Age 60+),  
San Diego County, 2010-2030

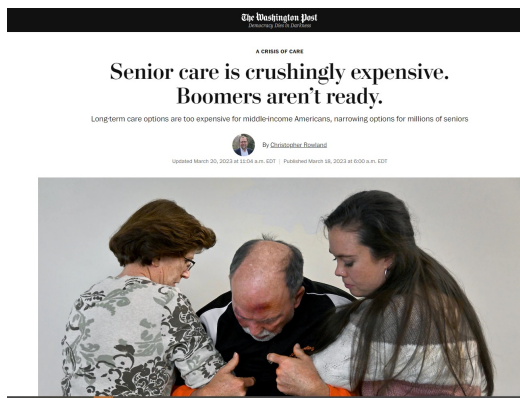


Source: State of California, Department of Finance. P-2: County Population Projections (2010-2060), P-2B County Population by Age. <https://dof.ca.gov/forecasting/demographics/projections/>. Accessed 7/11/2022.  
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2022.

# NEEDS: NATIONAL GAPS



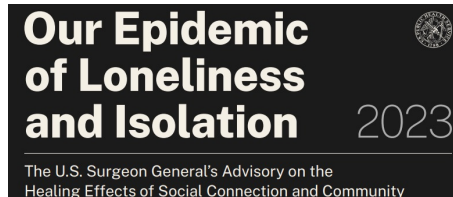
## Age-Friendly Public Health



Older adults nationally are being priced out of their apartments

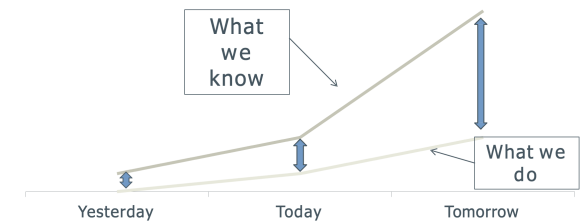
Can't afford help w/ADLs

## Age-Friendly Communities



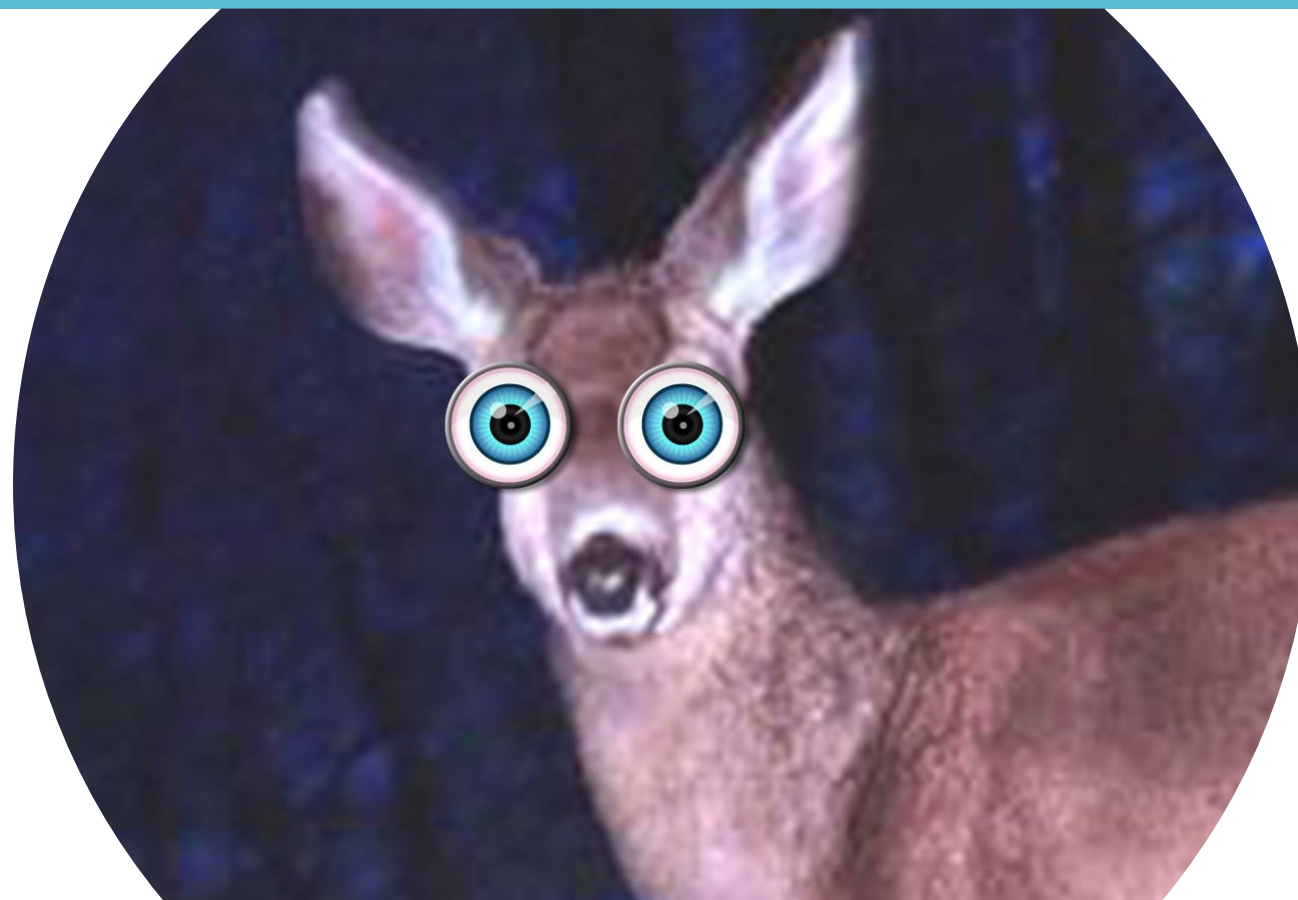
## Age-Friendly Clinical Care

### The Know-Do Gap



Only 30% of recommended evidence-based clinical care for older adults is implemented

# FIRST DAY AS CHIEF GERIATRIC OFFICER



# COUNTY OF SAN DIEGO'S AGING ROADMAP- PHEW!



Aging and Independence Services



CALL CENTER: 800-339-4661



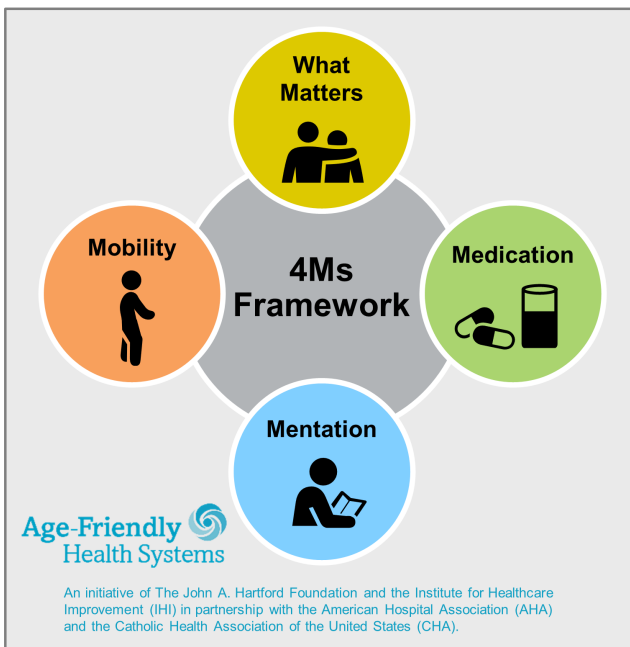
## CoSD AGING ROADMAP 10 FOCUS AREAS

- HOUSING
- TRANSPORTATION
- HEALTH & COMMUNITY SUPPORT
- MEDICAL & SOCIAL SERVICES SYSTEM
- SOCIAL PARTICIPATION
- PREPAREDNESS
- DEMENTIA
- CAREGIVER SUPPORT
- SILVER ECONOMY
- SAFETY

## CDA MASTER PLAN FOR AGING 5 FOCUS AREAS

- HOUSING FOR ALL STAGES AND AGES
- HEALTH REIMAGINED
- INCLUSION & EQUITY, NOT ISOLATION
- CAREGIVING THAT WORKS
- AFFORDABLE AGING

# AGE-FRIENDLY CLINICAL HEALTH CARE: THE 4MS



For related work, this graphic may be used in its entirety without requesting permission. Graphic files and guidance at [ihi.org/AgeFriendly](http://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.

## Age-Friendly Clinical Health Care aims to:

- Follow an essential set of evidence-based practices
- Cause no harm
- Align with what Matters with each older adult and their family



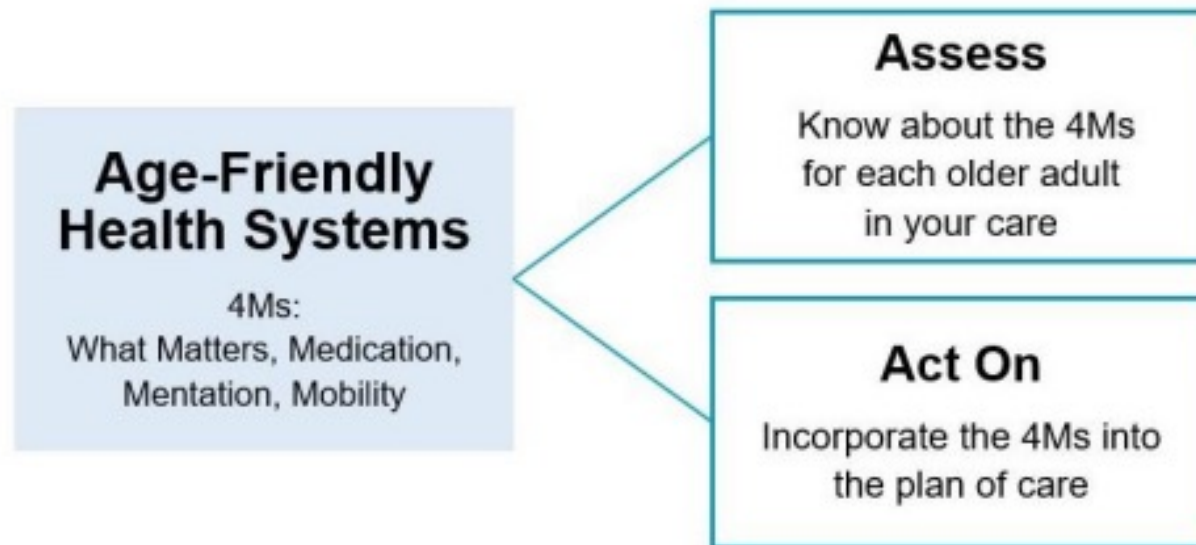
The John A. Hartford Foundation



American Hospital Association®



# AGE-FRIENDLY CLINICAL HEALTH CARE: ASSESSING AND ACTING ON EACH M



## WHAT MATTERS MOST



### **AIM**

**Assess** each older adult's specific health outcome goals and care preferences, including but not limited to End of Life Care

**Act on** /incorporate into care plan

# WHY WHAT MATTERS MOST IS WHAT MATTERS MOST



## Why What MATTERS Most is What Matters Most

### For older adults

- Values and we are the experts in ourselves
- Improved satisfaction with care

### For health care professionals

- Decrease burnout
- Increased adherence to care plans

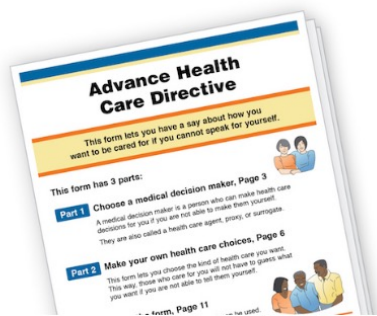
### For health systems

- Prioritize what people want and decrease costly unwanted care
- Quality metrics: HEDIS Measure (as well as PRIME, QIP, etc.)

# WHAT MATTERS – ASSESS



## Advance Care Planning



<https://prepareforyourcare.org/en/welcome>

## Current Care Planning



Choosing what matters.  
Doing what works.



[Myhealthpriorities.org](https://myhealthpriorities.org)

[Cancer. 2021 Oct 1; 127\(19\): 3631–3639.](#)  
[J Palliat Med. 2018 Jun 1; 21\(6\): 853–856.](#)

# WHAT MATTERS- ASSESS CURRENT CARE PLANNING



[MyHealthpriorities.org](https://myhealthpriorities.org)

Review and Print your Summary

NAVIGATION MENU

- Introduction
- 1. Identify What Matters Most to You
- 2. Set Your Health Goal
- 3. Review Your Health Symptoms and Problems
- 4. Review Your Health Care Tasks and Medications
- 5. Choose The One Thing to Focus On
- Talk With Your Health Care Team

## Institute for Healthcare Improvement What Matters Most Toolkit

### Guiding Questions: Understanding Life Context and Priorities

- 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?
- How do you learn best? For example, listening to someone, reading materials, watching a video.

J Am Geriatr Soc. 2019 Apr;67(4):665-673. doi: 10.1111/jgs.15809

# WHAT MATTERS MOST- THEMES



Choice and connection

As we age, most people want to feel

**engaged, valued, and empowered** to

Live how, where, and with whom we choose

regardless of race/ethnicity, income, sexuality, ability, etc.

# WHAT MATTERS MOST- ACT



## BRIDGING THE MEDICAL SOCIAL DIVIDE



### CoSD AGING ROADMAP 10 FOCUS AREAS

- HOUSING
- TRANSPORTATION
- HEALTH & COMMUNITY SUPPORT
- MEDICAL & SOCIAL SERVICES SYSTEM
- SOCIAL PARTICIPATION
- PREPAREDNESS
- DEMENTIA
- CAREGIVER SUPPORT
- SILVER ECONOMY
- SAFETY

*The San Diego Union-Tribune*



# MIND (MENTATION)



## AIM

**Assess**/identify delirium, depression, and dementia across the continuum of care

**Act**/provide evidence-based prevention, treatment, and management



# MIND (MENTATION)- ASSESS DELIRIUM VS. DEPRESSION VS. DEMENTIA



Domains of distinction	Delirium	Depression	Dementia
<b>Validated Screening tools</b>	<a href="#">UB-2</a> , <a href="#">CAM</a>	PHQ-2, PHQ-9, <a href="#">GDS</a>	<a href="#">Mini-Cog</a> , <a href="#">AD8</a> , <a href="#">GP-COG</a> , <a href="#">FAQ</a>
<b>Onset</b>	<b>Hours to days</b>	Weeks to months	<b>Months to years</b>
<b>Course and duration</b>	<b>Fluctuating, hours to days, reversible often medical cause</b>	May be chronic	<b>Progressive, irreversible</b>
<b>Self-Awareness</b>	May be aware of changes or fluctuation	Likely to be concerned about memory	May hide or be unaware of deficits
<b>Common tests</b>	CBC, CMP, TSH, B12, UDS, BAH, r/o ID (e.g., UA, Cxray), +- CT	CBC, CMP, TSH, B12,	CBC, CMP, TSH, B12, RPR, HIV, +- MRI
<b>Management</b>	<b>Underlying medical cause</b>  Medications, Mobility, Sensory	Cognitive Behavioral Therapy  SSRIs	Pharmacologic therapies (AChEIs, NMDA, Anti-monoclonals)  Comprehensive Dementia Care!

# DEMENTIA- EXAMPLE ASSESS BRAIN HEALTH



**THE ALZHEIMER'S**Project  
San Diego unites for a cure and care

## The Cognitive Health Assessment [www.dementiacareaware.org](http://www.dementiacareaware.org)

(CHA) a screen for dementia (aka brain health)

Part 1



**Take a Brief Patient History**

Part 2



**Use Screening Tools**

Part 3



**Document Care Partner Information**

Goal: Screen patients 65 and older annually (who do not already have a diagnosis of dementia)



# DEMENTIA – ACT COGNITION, FUNCTION, AND SUPPORT



Aging and Independence Services

CALL CENTER: 800-339-4661.

If the Cognitive Health Assessment (Dementia Screen) is positive, then further evaluate and address:

COGNITION	FUNCTION	SUPPORT
Screen for depression and substance use	Based on functional assessment, connect patients to services depending on need. Especially consider	Document the roles and contact information for the patient's support system, including:
Eval for other diseases with cognitive symptoms (e.g., HIV, syphilis, thyroid, OSA, Vit B12 deficiency)	In-Home Supportive Services, PACE, etc.	Care partner for the CHA screen
Order labs (e.g., CBC, electrolytes, BUN/Cr, HbA1C) and head imaging (if <12 mos of sx)	Money management services	Support persons or additional care partners
Take more detailed cognitive sx history, consider referral to a specialist (Neurologist, Geriatrician, Geriatric Psychiatrist)	Meal delivery services	<b>Health care agent(s) or durable power of attorneys</b>
Start a <b>Brain Health Plan</b>	Legal services for access to benefits through Medi-Cal and other programs	Connect patient to support system as needed to assist with medical and financial advance care planning



Southern Caregiver Resource Center  
*Caring for those who care for others*

**ALZHEIMER'S ASSOCIATION®**

**Alzheimer's | SAN DIEGO**

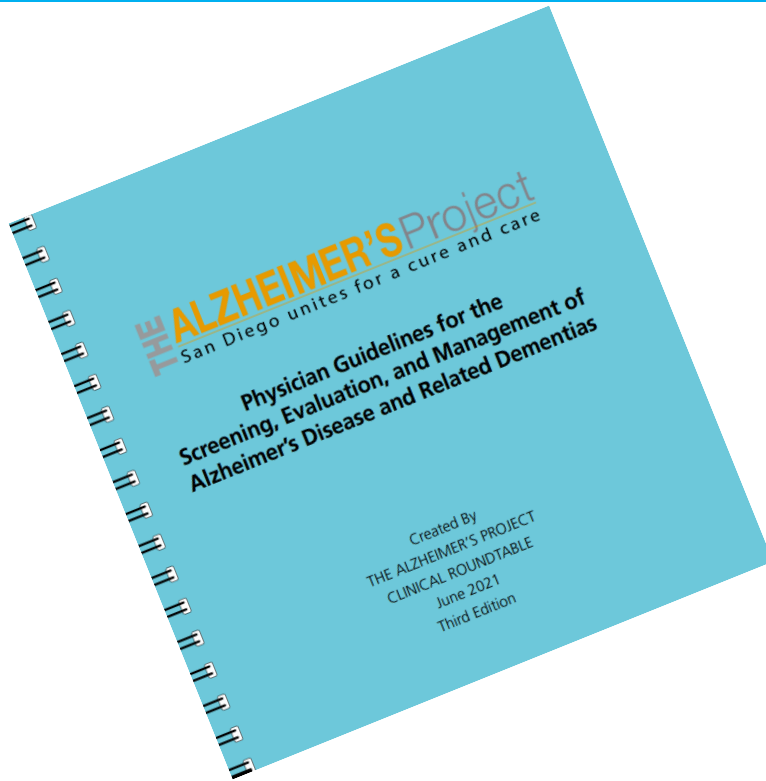


County of San Diego (.gov)  
<https://www.sandiegocounty.gov/sdc/programs/mcsd>

San Diego Advancing and Innovating Medi-Cal (SDAIM)



# DEMENTIA –ACT ADDRESS COGNITION AND FUNCTION



## Services & Offerings



**Online Courses**  
Reinforce your learnings with additional self-paced trainings! Each offer FREE .5 CE/CME/MOC



**Webinars**  
Attend monthly CME/CE-accredited live 60-minute webinars that present information on a variety of topics about dementia care.



**Interactive Case Conferences (ECHOs)**  
Learn more in interactive and case-based live meetings with Dementia Care Aware experts.



**Warmline Services**  
Live consultants, available 9 am - 5 pm PST, are ready to answer your questions. Call 1-800-933-1789.



**Practice Support Consultation**  
Hands-on guidance and skill building for your practice and resources to make meaningful improvements in daily practice.

Check back for 2024 update at Champions for Health  
<https://championsforhealth.org/alzheimers/>

Have questions about dementia care? Call Dementia Care Aware warmline for clinicians today at 1-800-933-1789, staffed by UCSF clinicians with expertise in dementia. Or contact [LindseyC.Yourman@sdcounty.ca.gov](mailto:LindseyC.Yourman@sdcounty.ca.gov)

# DEMENTIA –ACT COGNITION- START A BRAIN HEALTH PLAN



You can start a brain health plan to maximize brain function in all older adults, but it will especially benefit those with cognitive or functional decline

## **BRAIN HEALTH PLAN**

- Ensure up to date vision and hearing assessments; if impairments are present, correct accordingly
- Review medications for cognitive side effects and reduce as possible in dose, frequency, or trialing off completely
- Encourage social and physical activity
- Continue to address cardiovascular risk factors, such as blood pressure and diabetes
- Consider starting dementia medications only after an official diagnosis of mild cognitive impairment or dementia is made (at best current medications can slightly slow the progression of dementia for a limited amount of time, all have side effects, and there is no cure)

# DEMENTIA – ACT ACCESS SUPPORTS



People with Managed Medi-Cal who are diagnosed with dementia are within the population of focus: “at risk for institutionalization”, and can be referred to CalAIM Enhanced Care Management and Community Supports

The overlap between Enhanced Care Management and best practices in dementia care are detailed here

ECM component		Dementia care best practice
Outreach and engagement	☆	Partner with dementia friendly initiatives to generate referrals
	🗨️	Defined care manager role
Comprehensive assessment and care management plan	🗨️	Personalized and comprehensive care plan that is regularly updated according to the patient's needs
	🗨️	Care plan includes treatment and care management
	⚠️	Care plan includes medication management
Enhanced coordination of care	🗨️	Defined care manager role
Health promotion	🗨️	Caregiver education includes dementia education including managing stressors, medication management, self-management and community resources.
Transitional care services	🗨️	Defined care manager role
Member and family supports	🗨️	Care plan includes caregiver support
	🗨️	Caregiver support includes education on self-management
	⚠️	Caregiver assessment
Coordination of and referral to community and social Support Services	🗨️	Defined care manager role

🗨️ Overlap    ☆ Opportunity    ⚠️ Limitation

Overlap between these CS services and best practices in dementia care are detailed here

CS component		Dementia care best practice
Environmental accessibility adaptations (home modifications)	🗨️	Multicomponent interventions: safety intervention
Respite services	🗨️	Caregiver support: adult day programs
Personal care and homemaker services	☆	Supports identified barriers to access to care such as functional requirements and hour limitations for in-home support services
Medically tailored meals or medically supportive food	🗨️	Community dwelling intervention: home-delivered meals
Nursing facility transition or diversion to assisted living facility	🗨️	Community Dwelling Intervention: small-scale home-like care models

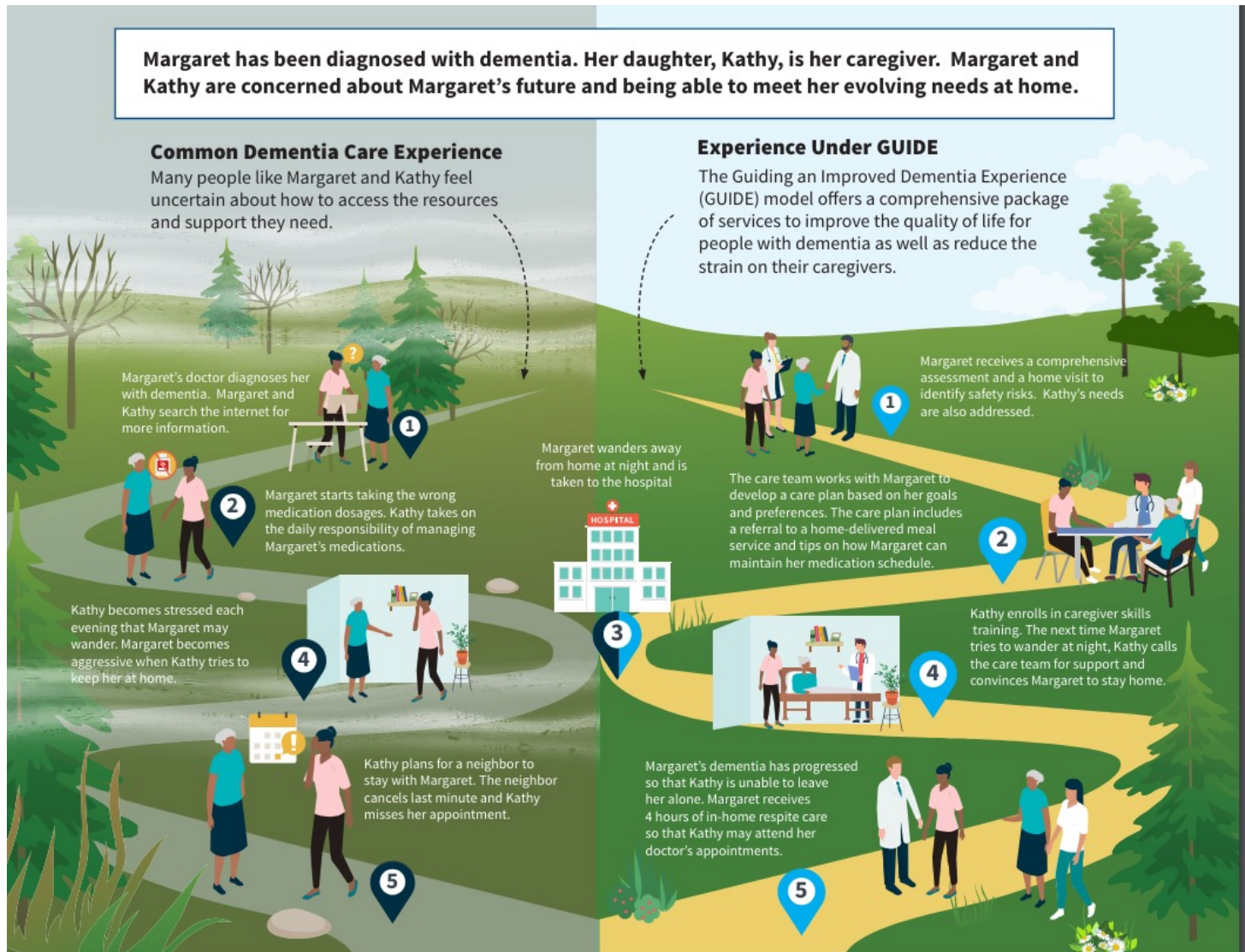
🗨️ Overlap    ☆ Opportunity



<https://archstone.org/uploads/ARCHSTONE-CALAIM-WHITEPAPER-FINAL-Nov-2023.pdf>

# GUIDE

Two health systems in San Diego County are participating in this novel Alternative Payment Model for whole person dementia care



# MEDICATIONS

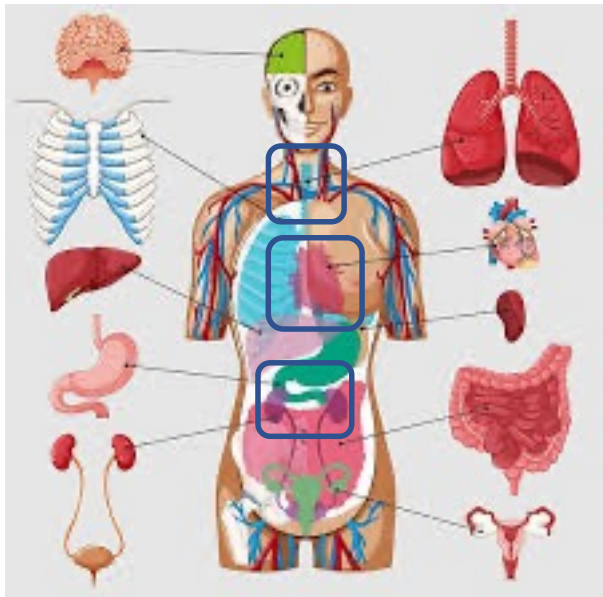


## AIM

**Assess** for potentially inappropriate medications

**Act** by using age-friendly medication that does not interfere with What Matters, Mind, or Mobility

# MEDICATIONS- WHY



- Age-related physiology ↑ risks of Adverse Drug Effects
  - ↓ # of functional glomeruli → ↓ renal clearance of drugs, toxins
  - ↑ Ventricular stiffness → ↓CO/vascular comp → orthostasis
  - Mucosal cell atrophy → constipation, etc., etc.
- Polypharmacy and Adverse Drug Events cause real problems for us as we age
  - Adverse drug events cause up to 30% of hospital admissions for older adults
  - Drug-drug and drug-disease interactions
  - Prescribing cascades

[Clin Interv Aging](#). 2016; 11: 497–505.

# MEDICATIONS- ASSESS AND ACT



1. **Make sure each medication is necessary** and given at age-adjusted dose ([CKD-Epi](#) for GFR etc.)



- Consider exclusion criteria of studies: Are the studies about this medication generalizable to your older patient?
- Is your patient's [life expectancy](#) longer than the [Time to Benefit](#) of the medication?
- Do the benefits of the medication outweigh the burdens in terms of your patient's preferences, values, and priorities?

2. **Ask about risks of each new medication** and when it should be stopped if not working

Beers is referenced in UpToDate under "Geriatrics"



<https://medstopper.com/>



# MOBILITY



## AIM

**Assess** for mobility risks and life space limitations (life space- how far can people travel safely from their room, are they able to do what matters to them?)

**Act on** by addressing both intrinsic and extrinsic risk factors for falls and gait instability

# MOBILITY - IMPORTANCE



- Age-related physiology that impacts mobility
  - ↓ otoliths → ↓ detection of gravity
  - ↓ number of neurons → ↓ fine motor control
  - ↓ pupil diameter → diff focusing near objects
  - ↑ fat/ ↓ type II fast twitch fibers → ↓ muscle tone and contractility
- **Falls** are the **leading cause of injury and injury death** among adults  $\geq 65$  years old
- **Mobility limitations** in older adults put them at higher risk for
  - disability
  - nursing-home placement
  - decreased quality of life (limiting life space)

# MOBILITY – ASSESS FALL RISK HISTORY



Patient completes  
**Stay Independent Brochure**  
 OR  
**Ask three questions**  
 (yes to any is at risk)



1. Feels unsteady when standing or walking?
2. Worries about falling?
3. Have fallen in past year?

## Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
<b>Total</b>		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. <b>Discuss this brochure with your doctor.</b>	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011; 42(6):493-499). Adapted with permission of the authors.

# MOBILITY – ASSESS EXAM- SCREENS FOR FALL RISK



**ASSESSMENT**  
**Timed Up & Go (TUG)**

**Purpose:** To assess mobility  
**Equipment:** A stopwatch  
**Directions:** Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

**NOTE:** Always stay to the side for safety.

**Instruct the patient:**

- When I say "Go," I want you to:
  - Stand up from the chair
  - Walk to the line on the floor at your normal pace.
  - Turn.
  - Walk back to the chair at your normal pace.
  - Sit down again.
- On the word "Go," begin timing.
- Stop timing after patient sits back down.
- Record time.

**Time in Seconds:** \_\_\_\_\_

An older adult who takes >12 seconds to complete the TUG is at risk for falling.

**OBSERVATIONS**

Observe the patient's postural stability, gait, stride length, and sway.

**Check all that apply:**

- Slow to rise from chair
- Loss of balance
- Short stride
- Little or no arm swing
- Straddling self on walk
- Shuffling
- Double turning
- Not using assistive device properly

These changes may signify neurological conditions that require further evaluation.

CDC STEAM tools and resources can help you screen, assess, and refer your patients to reduce their fall risk. For more information, visit <https://www.cdc.gov/steam>

**ASSESSMENT CONTINUED**  
**The 4-Stage Balance Test**

**Instructions to the patient:**

- Keep your feet shoulder-width apart.
- Place your right hand on the wall or on the back of the chair, but do not use your feet.
- Place your left hand on the wall or on the back of the chair, but do not use your feet.
- Do not grab onto anything. "Step up" onto the step using only your feet.

**1. Stand with your feet side-by-side.** Time: \_\_\_\_\_ seconds

**2. Place your right arm on the wall or on the back of the chair.** Time: \_\_\_\_\_ seconds

**3. Turn around. Place your feet in front of the other foot, feet shoulder-width apart.** Time: \_\_\_\_\_ seconds

**4. Stand on one foot.** Time: \_\_\_\_\_ seconds

**Notes:** \_\_\_\_\_

CDC STEAM tools and resources can help you screen, assess, and refer your patients to reduce their fall risk. For more information, visit <https://www.cdc.gov/steam>

**ASSESSMENT**  
**30-Second Chair Stand**

**Purpose:** To test leg strength and endurance  
**Equipment:** A chair with a straight back without arms with a seat 17" high, and a stopwatch.

**Instructions to the patient:**

- Stand behind the chair.
  - Place your feet on the floor in front of the chair.
  - Place your feet on the floor.
  - Place your feet on the floor.
  - Place your feet on the floor.
- On the word "Go" begin timing.
  - Stand up from the chair, hold the seat for 10 seconds, and sit back down.
  - Repeat the stand-up and sit-down cycle 5 times.
  - Stop timing after the 5th stand-up and sit-down cycle.
- Record the number of times the patient stands in 30 seconds.
  - If the patient is not ready to stand, do not start timing.
  - If the patient is not ready to sit down, do not start timing.
- Record the number of times the patient stands in 30 seconds.

**Notes:** \_\_\_\_\_

CDC STEAM tools and resources can help you screen, assess, and refer your patients to reduce their fall risk. For more information, visit <https://www.cdc.gov/steam>

**ASSESSMENT**  
**Measuring Orthostatic Blood Pressure**

**Instructions to the patient:**

- Have the patient lie down for 5 minutes.
- Measure blood pressure and pulse rate.
- Have the patient stand.
- Repeat blood pressure and pulse rate measurement after standing 1 and 3 minutes.

**Notes:** \_\_\_\_\_


CDC STEAM tools and resources can help you screen, assess, and refer your patients to reduce their fall risk. For more information, visit <https://www.cdc.gov/steam>

Name	Timed Up and Go	The 4-Stage Balance test	30-Second Chair Stand	Orthostatic Blood Pressure
Helps to assess	Overall mobility, gait and movement disorders	Static balance	Leg strength and aerobic endurance	Medication side effects, Dehydration, Medical conditions (cardiac, neurologic, endocrinologic, etc.)

# MOBILITY – ACT ON EXAMPLES OF FREE RESOURCES

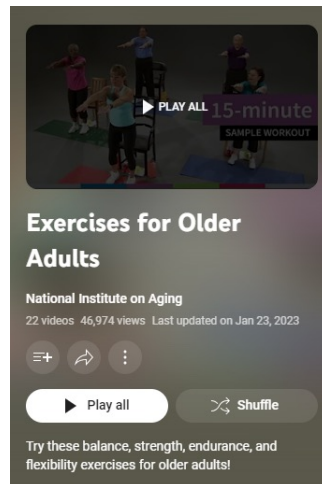


**NIH** National Institute on Aging

 Aging & Independence Services



**Exercise Videos for  
Older Adults, Safe  
to do at home**

A banner with a blue background on the left and a yellow background on the right. The blue section contains the text "FREE PROGRAMS IN SAN DIEGO". The yellow section contains the text "Most falls are preventable! San Diego County is home to several free programs that can help you stay healthy, active, and independent as you age." The background image shows people in a park setting.

## EVIDENCE-BASED FALL PREVENTION PROGRAMS

### TAI CHI

Involves slow, controlled movements to improve balance, stability, and coordination To learn more, call 858.495.5500 | [HealthierLiving.HHSA@sdcounty.ca.gov](mailto:HealthierLiving.HHSA@sdcounty.ca.gov)

### A MATTER OF BALANCE

Helps reduce fear of falling by coaching participants on how to view falls as controllable To learn more, call 858.626.6160

### BINGOCIZE

Incorporates exercise, nutrition, and fall prevention within the game of bingo To learn more, call 858.626.6160

# MOBILITY – ACT ON EXAMPLE MINIMIZE HOME HAZARDS



## Home Safety Checklist

### FLOORS

- Clear pathways of furniture and clutter
- Coil or tape wires and cords to the wall
- Secure rugs and carpets to the floor with double-sided tape (or remove)
- Do not use floor wax
- Remove low chairs that are difficult to sit in and get out of easily

### STAIRS AND STEPS

- Keep objects off the stairs
- Fix broken or uneven steps
- Fix loose handrails, or put in new ones on both sides of the stairs
- Install an overhead light and light switch at the top and bottom of the stairs
- Apply reflective tape to the bottom and top of the stairs

### KITCHEN

- Keep things you use often on the lower shelves (about waist high)
- Keep a Vial of Life or current list of health information on your fridge in the event of an emergency
- Never use a chair as a step stool

### BEDROOM

- Adjust bed height to a comfortable position

### LIGHTING

- Place a lamp close to the bed where it's easy to reach
- Install a nightlight so you can see where you're walking (some nightlights go on by themselves after dark)
- Replace burnt out light bulbs

### CLOTHING/ACCESSORIES

- Wear shoes that have a thin, non-slip sole
- Wear pants and dresses that have been hemmed so they don't touch the floor
- Carry a mobile or portable phone with you at all times
- Consider an emergency response system

### BATHROOMS

- Put a non-slip rubber mat on the floor of the tub or shower
- Install grab bars next to and inside the tub, and next to the toilet
- Consider using a raised toilet seat, padded shower seat, and/or handheld shower head

### OUTDOORS

- Repair cracks and gaps in the sidewalk or driveway
- Trim shrubbery along paths to the door



Consider referral to [CalAIM Community Support for Environmental Accessibility Adaptations](#) (Home Modifications)



**Environmental Accessibility Adaptations (Home Modifications)**

# SUMMARY



- We have a window of opportunity to adapt and optimize Age-Friendly Health Systems that meet the needs and leverage the strengths of older adults
- The 4Ms of Age Friendly Clinical Care are an essential set of evidence-based practices that do no harm and align with what matters most to each patient and their family (it's different for everyone)
- Addressing what Matters Most as we age requires whole person care that bridges the medical social divide
- This is all of us