

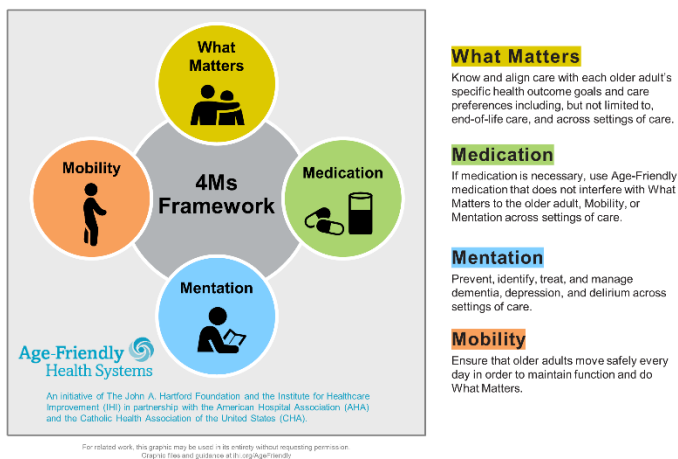
# How Education Supports Age-Friendly Health Systems in Home Health: Sutter Care at Home

## Background

Sutter Care at Home is a division of Sutter Health, a not-for-profit health care system in California and Hawaii with 22 acute care hospitals, 33 ambulatory surgery centers, and more than 300 ambulatory clinics as well as centers specializing in acute rehabilitation, cancer, cardiac, and mental health care. Sutter Care at Home extends the continuum of care from acute care hospitals and doctors' offices directly into patients' homes as one of the largest home health organizations in both California and the US.

Sutter Health participated in the home health prototyping initiative facilitated by Age-Friendly Health Systems. Age-Friendly Health Systems is an initiative The John A. Hartford Foundation, IHI, and the American Hospital Association. In this movement, age-friendly care is defined as care that is based in the 4Ms: What Matters, Medication, Mentation, and Mobility (Figure 1).

Figure 1. 4Ms Framework of an Age-Friendly Health System



adults 80 or older have a 4 percent share of the population. Currently, the population is 56 percent White (this category is decreasing), 20 percent is Hispanic (this category is increasing), 19 percent Asian, and 1 percent Black. Socioeconomic drivers of health for the county include: 8 percent of older adults do not speak any English, an estimated 12 percent have dementia, 20 percent of older adults live alone, and 51 percent of households are considered low-income, including 15 percent that meet the federal poverty threshold.<sup>1</sup> One unique factor for this Sutter Care at Home location is that it is not associated with an acute care hospital in the Sutter Health system and therefore must coordinate care with a hospital belonging to another health system.

Sutter Health has an organizational-level aim to develop a care navigation pathway that will promote a cohesive approach to age-friendly care across the care continuum. As a component of this aim, the team seeks to understand how community partnerships can better address unmet needs. For example, the team has developed partnerships with community organizations, such as the Alzheimer's Association of Northern California. Community organizations provide a key perspective for strategic planning and improve awareness of community resources to address unmet needs. Some organizations' leaders serve as co-faculty to strengthen education for Sutter Health team members.

The home health prototyping initiative fostered an "all teach, all learn" approach to implementation, which benefited this learning process.

## Aligning with AFHS

The team began with a gap analysis at the Yuba City pilot location on current home health practices and processes, in comparison to best practices for age-friendly care adapted to home health settings. Through a quality improvement approach that relies on small tests of change, the team sought Age-Friendly Health Systems — Commitment to Care Excellence (Level 2) recognition from IHI. After a delay related to manual processes necessary to conduct chart

## Caring for and With the Community

The home health division of Sutter Care at Home in Yuba City serves six counties and cares for more than 2000 patients during 36,000 home visits annually. In Sutter County, where Yuba City is the county seat, older adults aged 60-79 have a 17 percent share of the population and

reviews to confirm the number of older adults reached with 4Ms care, the team achieved the goal of recognition.

## What Matters

The team set out to pilot a modified way of inquiring about What Matters, with an initial aim to document that at least 60 percent of older adults were being asked what matters most to them in the development of meaningful and individualized health goals.

The Yuba City team had previously identified patient-specific goals using SMART formatting (Specific, Measurable, Attainable, Relevant, and Time-Bound). During an interprofessional planning meeting with the pilot site, Sutter Care at Home leaders, and system consultants, the group determined that a small shift could build upon this existing practice. The team decided to add an “M” for “Meaningful” to SMART. Direct care clinicians were trained to assess What Matters using communication strategies from IHI’s *“What Matters” to Older Adults Toolkit*.<sup>2</sup>

The interprofessional care team conducts weekly rounds on each patient, known locally as C3 Meetings. To support acting on what matters, the team changed the format for presenting a patient case to the team to first share why the patient health goals are meaningful to the individual. If a clinician forgets to begin their case presentation in this way, team leaders prompt, “What matters most to this patient?”

The team achieved and exceeded their aim. Three months after implementation, What Matters was identified, documented, and shared with the care team in rounds for 70 percent of all older adults.

## Medication

Sutter Care at Home already had a system-level policy to manage “High Risk/High Alert Medications” that promotes shared accountability among clinicians. Each home health team member assists with medication reconciliation and risk reduction. This process begins with comparing the current medication list with the actual medications present in the home, both prescription and non-prescription.

Team members ask clarifying questions, such as whether a patient is taking any medications belonging to a family member, how the medications are managed (to ensure appropriate dosing), and whether there are any access issues, especially for missing medications. They identify red flags such as the presence of duplicate prescriptions or three or more medications from the same drug class.

“Stoplight Tools” help patients identify reportable signs and symptoms for high-risk medications. While only licensed nurses can provide additional patient education and only physicians can change medication orders, all team members are expected to report concerns. Given this robust practice, support for medication assessment included a reminder to report medications that impair What Matters, Mentation, or Mobility.

Physicians review all reported medication concerns to evaluate whether the prescriptions can be discontinued or adjusted (dosage, frequency, or timing) to reduce risk. Any adjustments designed to improve Mentation or Mobility or to align with patient care preferences are documented in the team notes.

## Mentation

Although mentation screenings are a required component of OASIS-E2 documentation, the gap analysis found that screenings were completed 45 percent of the time and appropriate interventions provided 35 percent of the time. Discussion with team members revealed limited competency and confidence in screening, driven by knowledge gaps related to the conditions (such as delirium), contributing factors (for example, the increased likelihood of depression if cognitive impairment was present), tools, and strategies for management. The educational needs assessment was used to develop continuing education modules specific to mentation in home health settings.

Sutter Health’s Accredited Continuing Education (ACE) team provides system-level coaching on how to best integrate evidence-based practices into health care with the goal of optimizing individual patient health outcomes and improving population health. ACE team members work with the education lead to identify barriers and enablers to practice change and then recommend activity-specific interventions to improve education design and delivery. A “Train the Trainer” approach increased the number of age-friendly champions within home health.

Education included behavioral management strategies and resources to support families impacted by dementia. For example, Sutter Health used a software platform to build a database of free or reduced-cost social services programs<sup>3</sup> such as caregiver respite in the local area.

The team reviewed emergency escalation of any positive screens for depression on the PHQ-2 and PHQ-9 to the administrator on duty, medical social worker on call, and

the physician so that individuals with symptoms of depression and suicidal ideation can receive emergency life-saving interventions.

## Mobility

The home health team had a strong track record of supporting mobility. Ongoing rehabilitation is often a primary driver of home health referrals, and home health documentation has robust requirements home health documentation. The team had an existing commitment to identify individuals who may benefit from physical therapy (PT) and/or occupational therapy (OT) services when not included in initial referrals and to initiate these services within 5 days of the start of care. As a result, 80 percent of Yuba City home health patients receive PT or OT services necessary to promote progressive mobility and maintain function.

Team members shared that they felt encouraged, because the 4Ms Framework provided tools to strengthen the likelihood that mobility goals will be achieved. For example, knowing why a goal is meaningful can provide ongoing motivation. The team notes that greater attention to high-risk medications that impair mobility, or to the mentation concerns that can contribute to the fear of falling, supports a “whole-person” approach to home health care planning.

## Outcomes

Interprofessional collaborative education targeting specific needs of the team and minor changes to existing care processes resulted in clinically significant improvements. When the work began, only 10 percent of older adults were reached by 4Ms care. After the first 3 months of implementation, the Yuba City team assessed the 4Ms for 60 percent of older adults and acted on the 4Ms with 50 percent of older adults.

A number of older adults have stated that they feel listened to when their answer to What Matters is used to develop the goals of care. The team begins each meeting with an invitation to share stories of impact for older adults, family members, and direct care clinicians. They hope to develop improved mechanisms to collect patient-reported outcomes, as well as regular review of trends in stratified data.

## Lessons Learned

Highlights from the work included:

**Touchpoints about tests of change.** The team held bi-weekly meetings to evaluate implementation and identify additional opportunities and barriers. Frequent tests of change generated new ideas, such as social influence strategies. The Yuba City team designed and ordered What Matters badge ribbons for each team member. The badge ribbons became both a visual reminder to the clinician to ask the patients what matters, as well as a conversation starter with patients and families to provide information about age-friendly care as well as encourage self-advocacy for care that aligns with what matters.

**Tailored training.** Team members reported improved confidence in their competencies related to mentation. As a result of education that directly addressed the challenges and complexities of delirium, dementia, and depression, team members felt that effective management strategies were possible.

**Change management at all levels.** The planning team initially garnered support in meetings with C-suite health system executives and local leaders in home health. Not long after the work began, a mid-level executive requested a stop to implementation. The team worked to understand the executive’s priorities to better demonstrate how age-friendly care aligns with those aims. They also realized that change management is a key consideration for all levels of leadership, especially in large and complex health system.

**Increased meaning in work.** As a rural site with more limited resources, often caring for patients with challenging socioeconomic circumstances, the team acted as pioneers of the age-friendly approach in home health. Team members report asking what matters has made individualized goal planning more effective. Several team members reported an increased connection to purpose. Many team members shared personal stories of care that dismissed older adults’ concerns and caused harm. They are inspired to achieve care focused on what matters for older adults they care for personally and professionally.

**Collaboration across the system.** The team has grown relationships with teams across the organization, such as Sutter Health’s Institute for Advancing Healthy Outcomes (IAHO). They hold monthly “all teach, all learn” meetings with recognized Age-Friendly Health Systems sites from all care settings. Members of the ACE team provided key support outside of their usual responsibilities. With the

implementation of a new electronic health record (EHR) just six months away, the team could not modify the existing EHR to track progress. ACE team members went above and beyond, volunteering to support manual chart audits and data stratification for two locations to reduce the administrative burden on the home health team while advancing the shared goal of age-friendly care.

## Spreading Success

After successful implementing changes in Yuba City, the team piloted these age-friendly adaptations to care practices (Table 1) at the Roseville home health location to check for unique barriers or enablers at a new site. Finding none, the implementation team worked on a staged rollout at each home health location within Sutter Care at Home. Sutter Health also went on to participate in the Age-Friendly System-Wide Spread Collaborative for US health systems interested in fully embedding the 4Ms system-wide.<sup>4</sup> Sutter Care at Home includes 15 locations; all of them have achieved Age-Friendly Health Systems – Commitment to Care Excellence recognition.

**Table 1. Pilot Practices**

Focus Area	Assess	Act On	Key Points
<b>What Matters</b>	<u>Small Shift in Perspective:</u> SMART goals that identify what is Meaningful to the patient.	<u>C3 Meeting Report Out:</u> "What matters to this patient?"	All Clinicians, All Encounters
<b>Medication</b>	<u>Continue to Assess:</u> High-risk & potentially inappropriate medications (per policy)	Physician will determine if any potentially inappropriate medications can be d/c'd or have the dose and/or timing changed	All Clinicians can help identify medication risk and report it to the provider
<b>Mentation</b>	<u>Continue to Assess:</u> Delirium, Dementia & Depression in OASIS-E	<u>Management Plan:</u> Document appropriate interventions or referrals	All Clinicians can receive education from system mentor to improve confidence in assessment & next steps
<b>Mobility</b>	<u>Continue to Assess:</u> Mobility, Functional Abilities & Safety in OASIS-E	<u>Management Plan:</u> Document a mobility plan that promotes progressive improvement	This is already an area that Sutter Care at Home SHINES!

## Acknowledgments

*The Institute for Healthcare Improvement is grateful to the Sutter Health team who devoted their time and passion to this work.*

### What Is an Age-Friendly Health System?

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," to all older adults: What Matters, Medication, Mentation, and Mobility.

Visit: [ihi.org/AgeFriendly](https://ihi.org/AgeFriendly)

## References

<sup>1</sup> California Department of Aging. [2025 Profile of Older Adults: Sutter County](#).

<sup>2</sup> Laderman M, Jackson C, Little K, Duong T, Pelton L. ["What Matters" to Older Adults? A Toolkit for Health Systems to Design Better Care with Older Adults](#). 2019

<sup>3</sup> Sutter Health. Sutter Resources. <https://sutterresources.findhelp.com>

<sup>4</sup> Institute for Healthcare Improvement [Age-Friendly System-Wide Spread Collaborative](#).