Institute *for* Healthcare Improvement

Age-Friendly Health Systems:

Guide to Care of Older Adults in Home Health Care

January 2025

ihi.org/AgeFriendly

This content was created especially for:

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Acknowledgments

This work was made possible by The John A. Hartford Foundation, a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. For more information, visit www.johnahartford.org.

IHI would like to thank our partners, the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHAUSA), for their leadership and support of the Age-Friendly Health Systems initiative.

Thank you to the organizations who participated in the prototyping for home health care: Advocate Health Care, BAYADA Home Health Care, CommonSpirit Health, Enhabit Home Health & Hospice, Northwell Health, and Sutter Health.

IHI is thankful to the Age-Friendly Health Systems faculty and advisory group. We extend our deepest gratitude to the Age-Friendly Health Systems co-chairs Don Berwick, MD, MPP, Faith Mitchell, PhD, and Jonathan Perlin, MD; and to founding co-chairs Ann Hendrich, PhD, RN, and Mary Tinetti, MD.

Learn more at ihi.org/Age-Friendly.

Institute for Healthcare Improvement

For more than 30 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

Contents

Introduction

This Age-Friendly Health Systems **Guide to Care of Older Adults in Home Health Care** is a companion document to Age-Friendly Health Systems: **A Workbook for Home Health Care**. The two documents are designed to be used together to help home health care organization teams prepare for, test, and implement a specific set of evidence-based age-friendly care practices referred to as the 4Ms Framework.

Both the Guide and Workbook outline the 4Ms in the care of older adults in home health care is defined as skilled nursing or rehabilitation services, provided by licensed health professionals like nurses and physical therapists, ordered by a clinician, and delivered at home.

- This Guide provides recommendations for how to implement a series of actions system-wide (throughout the home health care organization teams). It also provides recommendations for how to build the will for change and how to communicate about the 4Ms to all home health care recipients, caregivers[i], and staff members in order to engage the entire community in promoting age-friendly care.
- The Workbook is designed to be practical and easy to use in daily practice, and includes printable worksheets that team members (including home health aides) working directly with individual care recipientss may use to deliver age-friendly (4Ms) care. The Workbook was developed with expert faculty and advisors, and six prototyping teams comprised of two home health care organizations and four health systems.

Age-Friendly Health Systems Overview

The United States population is aging and becoming increasingly diverse. As of 2024, 16.5 percent of the US population is now age 65 or older, amounting to more than 54 million older adults.[1] From 2010 to 2020, the number of older adults who identify as Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, multiple races, or some other race other than White grew from 15 percent to 23 percent, while the Hispanic or Latino population of older adults increased from nearly 7 to nearly 9 percent.[2]

As we age, care often becomes more complex. Health systems are frequently unprepared for this complexity, and older adults suffer a disproportionate amount of harm while receiving care in the health system. Older adults from historically marginalized communities suffer from disparate treatment that negatively influences health outcomes.

---

[i] **Care partner or caregiver**: A person (family member, friend, neighbor, coworker, other) who supports an older adult/patient/resident with physical, psychological, financial, spiritual, or other issues related to health.

To address these challenges, in 2017, The John A. Hartford Foundation (JAHF) and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), set a bold vision to build a social movement so that all care with older adults is age-friendly care.

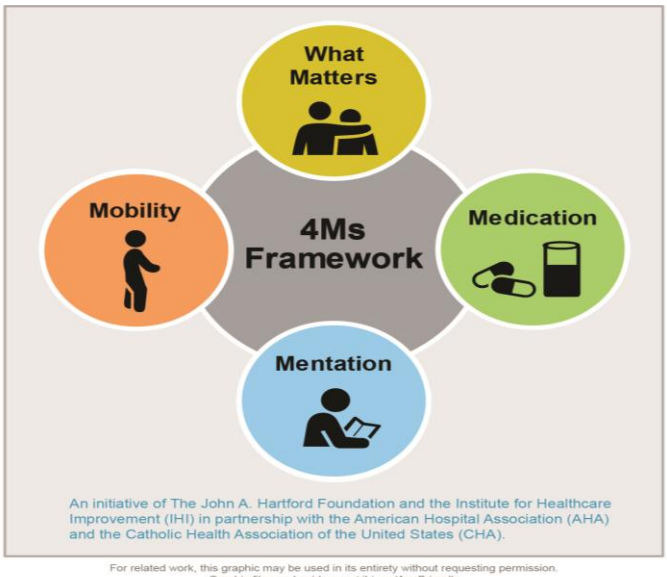
According to our definition, age-friendly care:

- Follows an essential set of evidence-based practices;
- Causes no harm; and
- Aligns with What Matters to older adults and their care partners.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality equitable care, known as the "4Ms," to all older adults served by your home health care organization and across your health system. When implemented together, the 4Ms represent a broad shift by health systems to focus on the needs of older adults (see Figure 1).

The Age-Friendly Health Systems movement now comprises more than 4,900 hospitals, practices, convenient care clinics, nursing homes (including post-acute and long-term care settings — e.g., SNFs and nursing facilities), and home health care organizations working to reliably deliver evidence-based care with and for older adults. IHI and JAHF celebrate the participation of organizations that have committed to practicing age-friendly 4Ms care. Learn more about how you can join the movement and show your commitment to better care for older adults at ihi.org/AgeFriendly.

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



The 4Ms — What Matters, Medication, Mentation, and Mobility — make complex care of older adults more manageable. The 4Ms identify core issues that should drive care and decision making with older adults. The 4Ms organize care and focus on an older adult's wellness and strengths rather than solely on disease. The 4Ms are relevant regardless of an older adult's individual disease(s). They apply regardless of the number of functional problems an older adult may have; that person's cultural, ethnic, or religious background; or their socioeconomic status.[3]

The 4Ms are a framework, not a program, to guide care of older adults wherever and whenever they come into contact with a health system's care and services. The intent is to equitably incorporate the 4Ms into existing care, rather than layering them on top, in order to organize efficient delivery of effective care. This integration is achieved primarily through redeploying existing resources.

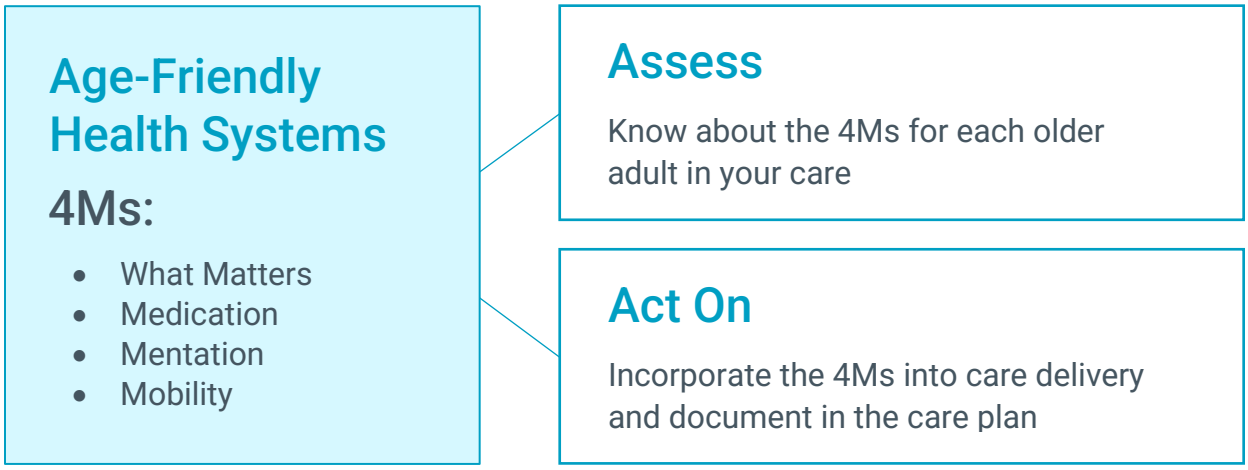
Many home health care organizations have found that they already provide care aligned with one or more of the 4Ms for many older adults. New work involves organizing care equitably so that all 4Ms, as a set of evidence-based practices, guide every encounter with every older adult and, when appropriate, their family or other designated care partners.

4Ms Framework: Not a Program, But a Shift in Care

- The 4Ms Framework is not a program, but a shift in how we provide care to older adults.
- The 4Ms are implemented together (i.e., all 4Ms as a set of evidence-based elements of high-quality care for older adults).
- Your home health care organization probably practices at least a few of the 4Ms in some places, at some times. Engage existing champions for each of the 4Ms. Build on what you already do and spread it consistently across your system.
- The 4Ms must be practiced reliably and equitably (i.e., for all older adults, in all settings and across settings, in every interaction).

There are two key drivers of age-friendly care (see Figure 2): knowing about the 4Ms for each older adult in your care ("assess"), and incorporating the 4Ms into care delivery and documentation in the care plan ("act on"). Both must be supported by documentation and communication across settings and disciplines.

Figure 2. Two Key Drivers of Age-Friendly Health Systems



Developed with our expert faculty and advisors, and six prototyping teams comprised of two independent home health care organizations and four health systems, this Age-Friendly Health Systems Guide to Care of Older Adults in Home Health Care is designed to help care teams test and implement a specific set of evidence-based best practices that correspond to each of the 4Ms. This Guide outlines the 4Ms for home health care settings. For guidance specific to the care of older adults in hospitals and ambulatory practices, please refer to the Guide to Using the 4Ms in the Care of Older Adults.[4] For guidance specific to the care of older adults in nursing homes, please refer to the Guide to Using the 4Ms in the Care of Older Adults in Nursing Homes and accompanying Workbook.

Implementing the 4Ms in Home Health Care Settings

Home health care for the Age-Friendly Health Systems movement is defined as: Skilled nursing or rehabilitation services, provided by licensed health professionals like nurses and physical therapists, ordered by a clinician, and delivered at home. For other types of home health services, such as home-based primary care or hospital at home, home health care organizations can use the existing ambulatory and hospital 4Ms Care Descriptions and recognition pathway at ihi.org/agefriendly.

Home health care services are an essential component of the US health care system serving some 15 million patients each year, 70 percent of whom are age 65 or older[5]. Currently home health care providers travel more than 5 billion miles per day to make more than 600 million patient visits to older adults who would overwhelmingly prefer to receive care in the comfort of their homes[6]. The 4Ms Framework of an Age-Friendly Health System provides an evidence-based approach for home health care clinicians to engage older adults as partners in care and support them to achieve their health care goals.

Most home health care providers provide some 4Ms care some of the time to some older adults in their care. However, the set of 4Ms interventions is often not reliably or equitably delivered.

Because care is provided within the home, comprehensive, integrated care is critical to achieving the older adult's goals and positive health outcomes. Multiple team members visit older adults and staff (e.g., pharmacy consultants, therapists, nutrition consultants, psychiatric consultants, medical team members) at different times. Unlike in a nursing home or hospital, the older adult does not have a professional care provider present throughout the day. Therefore, it is crucial that each home health care provider have 4Ms practices and protocols written out, so that all team members are oriented to optimal and accepted visit and communication practices across settings.

The Age-Friendly Health Systems movement provides an integrated, evidence-based foundation from which to consistently deliver 4Ms care to all home health care recipients, all of the time.

Equity and diversity are critical issues across all health care settings, including in home health care. One study demonstrated that Black and Hispanic older adults have a lower probability of using high-quality home health organizations by 2.2 percent and 2.5 percent respectively, compared to their White counterparts within the same neighborhood[7]. The same study found that low-income older adults had a lower probability of using home health compared to higher-income older adults[8]. Capturing quality data stratified by race, ethnicity, sexual orientation, gender identity, and other characteristics will help identify opportunities to provide care equitably across all populations. Diversity and equity are vital for staff as well.[9,10]

This Guide references or includes tools, worksheets, and appendices. Teams may choose to instead use similar tools and worksheets that are part of Age-Friendly Health Systems: **A Workbook for Home Health Care Teams**. Whether your team chooses to use the tools in the Guide or in the Workbook, it is not necessary to complete both sets of documents for each topic.

Putting the 4Ms into Practice

Experiencing age-friendly care as a staff member…and as a family member

When I was approached about my office being a pilot site for Age-Friendly Health Systems (AFHS) I was skeptical and honestly felt it was going to take a lot of time and time is precious. Now, over a year later, I had no idea I was going to witness age-friendly care in such a personal way.

My mom went to the hospital and nearly died. She was admitted and asked questions about What Matters like: What brings you joy? What matters the most to you? What concerns you the most about your health? Her room had a white board with the questions and answers on it. What was important to her was that she would not have to endure anymore "pokes." She is a frail, 90 pound, 90-year-old lady whose arms were "beat up."

The team that cared for her did everything they could to keep from any further lab or IVs unless absolutely necessary. Her questions were asked more than once during her stay and her wishes were addressed as much as possible.

Mom came home and started physical therapy with home health. The therapist asked Mom the same questions. With a smile on her face, she laughed and said, "Oh, here we go again." She stated that being able to stay home and get stronger were the top priorities. After the clinician left she said "I get it now, they are all supposed to know what I really want."

Her therapists have worked diligently with her and reinforced how far she has come. They have encouraged her all the way, showing her how she can do what she wants to do. They have become important to Mom and their relationship with her has added to the progress. They found what mattered and helped her accomplish her goals.

I am so grateful for AFHS as I have seen it work over the various levels of health care. True care comes from being in a relationship with the patient. Age-friendly care helps build that relationship, with the return being focused, intentional care working towards a goal that matters to the patient.

Karen Snavely, BSN,RN; COS-C; Regional Director of Clinical Services
CommonSpirit Health

The 4Ms as a set may be integrated into care by following six steps:

Step 1. Understand your current state

Step 2. Describe care consistent with the 4Ms

Step 3. Design or adapt your workflow to deliver care consistent with the 4Ms

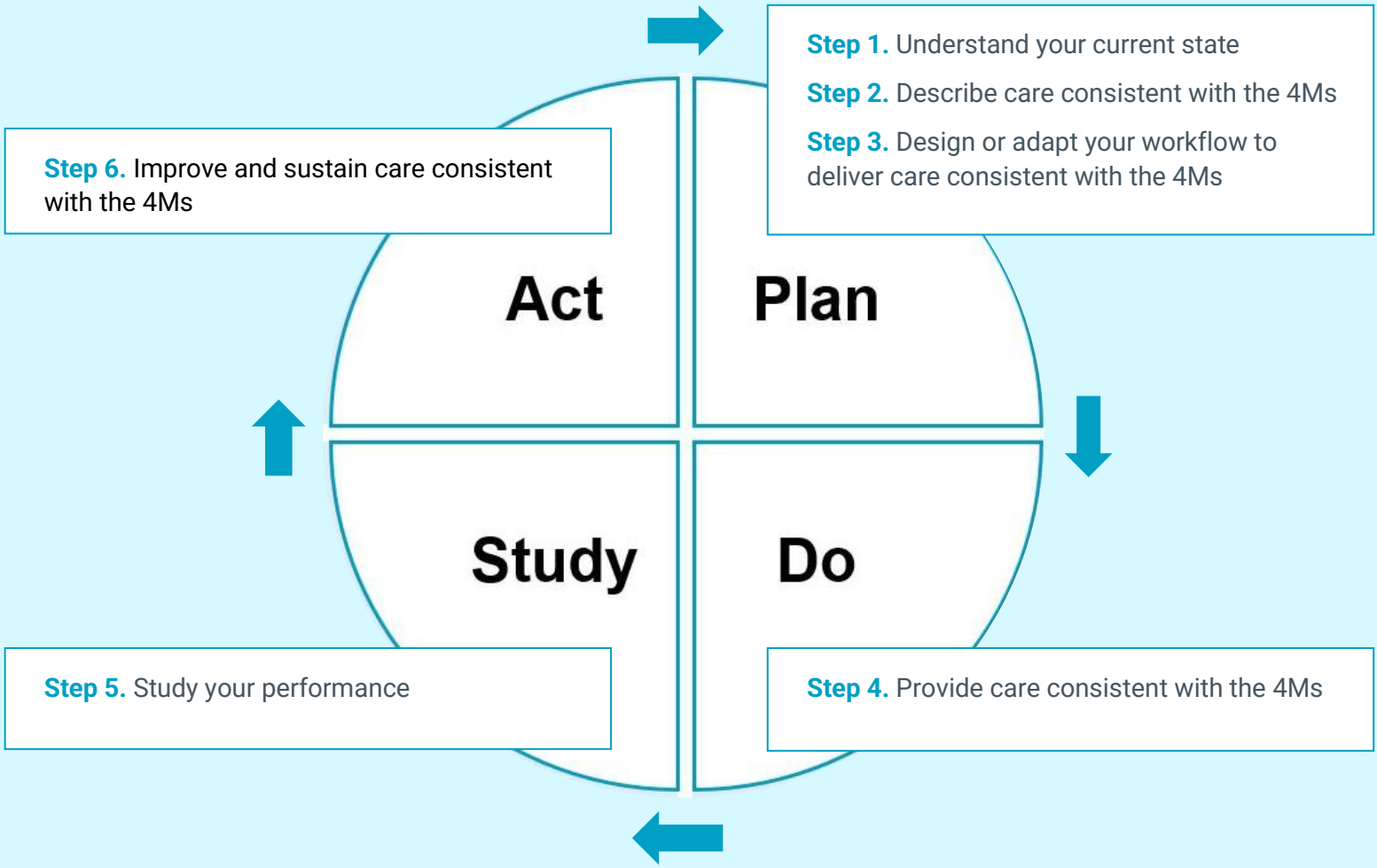
Step 4. Provide care consistent with the 4Ms

Step 5. Study your performance

Step 6. Improve and sustain care consistent with the 4Ms

While we present the five steps as a sequence, in practice you can approach Steps 2 through 5 as a loop aligned with Plan-Do-Study-Act (PDSA) cycles[11] (see Figure 3).

Figure 3. Integrating the 4Ms into Care Using PDSA Cycles



The impact of 4Ms care

After a hospitalization for urinary retention and acute kidney injury, David (not his real name) was referred to home health services. He had a complex medical history, including uncontrolled diabetes, hypertension, schizophrenia, Stage 4 chronic kidney disease, benign prostatic hyperplasia (BPH or enlarged prostate), and depression. Living alone in a single-family home, he was easily confused, forgetful, and struggled with poor health literacy and limited understanding of his medical conditions.

The local area visits team first prioritized understanding David's needs and goals **(What Matters)**, with the goal of managing medications and his chronic disease so that he can live more independently. Recognizing his forgetfulness and confusion, the nurse and the team focused on **Medication** adherence, ensuring that David could maintain independence and avoid further complications. The team also identified critical gaps in his medication management, including non-adherence and untreated schizophrenia. By coordinating with the psychiatrist, physician, and pharmacy, they provided structured support, such as a pre-filled medication box for David to use and appropriate psychiatric treatment. This led to improvements in his physical health (addressing urinary retention and acute kidney injury) and his cognitive functioning.

Untreated schizophrenia and depression were contributing to David's confusion and forgetfulness. The team's efforts to address psychiatric medication helped reduce cognitive challenges **(Mentation)** and improved his ability to engage in his care. **Mobility** was further supported by supporting medication adherence and improved mental clarity, which helped David remain independent in his daily life at home.

Age-friendly care also had a profound effect on the health care staff. Enhanced collaboration and communication resulted in an integrated care plan developed by the entire team (nurse, physician, psychiatrist, pharmacist). The staff reported increased job satisfaction from seeing the fulfillment of David's goals and improvement in his quality of life. The strategic approach of the 4Ms Framework empowered the team to navigate complex influences and deliver effective, compassionate care.

Wendy Wendy Cerminara, MSPT; Director Clinical Ops, Visits (COS)
BAYADA Home Health Care

Step 1. Understand Your Current State

The aim of an Age-Friendly Health System is to reliably apply the two key drivers of age-friendly care with all older adults: knowing about the 4Ms for each older adult in your care ("assess"), and incorporating the 4Ms into care delivery and documenting in the care plan ("act on"). Almost all systems integrate some of the 4Ms into care, some of the time, with some older adults, in some places. With an understanding of your current experience and capacity to engage in 4Ms care, you can build on that good work until the 4Ms are reliably practiced with all older adults.

The following steps help you prepare to become an Age-Friendly Health System by understanding your current state — knowing older adults in your care, and identifying the 4Ms or other relevant clinical practices in your home health care organization — and then establishing a team to begin testing changes to practices and workflows to align with age-friendly (4Ms) care.

Know the Older Adults in Your Organization

Estimate the number of adults you served in each age group in the last month (see Table 1).

Table 1. Adults Served in the Last Month (by Age Group)

Age Group	Number	Percent of Total
18–64 years		
Older Adults:		
65–74 years		
75–84 years		
85+ years		
Total Number of Adults		**100%**

For each older adult, specify: primary or preferred language, race, ethnicity, sexual orientation, gender identity, cultural and religious preferences (see Table 2), and health literacy levels (see Table 3).

Table 2. Older Adults' Language, Race, Ethnicity, Cultural and Religious Preferences

Primary or Preferred Language	Percent of Total Older Adults
Race	**Percent of Total Older Adults**
Sexual Orientation/Gender Identity	**Percent of Total Older Adults**
Ethnicity	**Percent of Total Older Adults**
Cultural Preferences	**Percent of Total Older Adults**
Religious Preferences	**Percent of Total Older Adults**

Table 3. Health Literacy Levels of Older Adults*

Health Literacy Level	Estimated Percent of Total Older Adults
Low	
Moderate	
High	

* To screen for health literacy, try using a tool like the Short Assessment of Health Literacy–Spanish and English, Rapid Estimate of Adult Literacy in Medicine–Short Form, or Short Assessment of Health Literacy for Spanish Adults, which are all freely available online from the Agency for Healthcare Research and Quality (AHRQ). The team may also want to ask about learning preferences, such as how each person prefers to receive information (e.g., verbally, reading, watching on TV, social media). For example, the provider might screen for health literacy and learning preferences at the start of care and upon significant change in status that would affect literacy and learning preferences. Patients with lower health literacy are at at higher risk of hospital readmissions[12]. By addressing and improving health literacy, home health organizations can help reduce acute events like readmissions, while improving overall health care effectiveness and safety.

Identify the 4Ms in Practice in Home Health Care

To identify where the 4Ms are in practice in your organization, walk through activities as if you were an older adult or care partner. In the home health care setting, that may include preparing for a visit ordered by a provider (doctor, nurse practitioner, or physician assistant), observing a visit, review your organization's standard work and competencies your newly hired clinicians should know before they are sent into the field, and understanding who takes responsibility for each of the 4Ms across the care team. Go through the process when an older adult begins receiving home health care, spend time with a care team or provider as they travel to different homes, and accompany home visits from different providers. Look for the 4Ms in action. Observe the workflow and look for gaps or duplication of efforts. Find bright spots, opportunities, and champions of each of the 4Ms in your organization.

Use the checklist in Appendix A to note what you learn.

An Age-Friendly Health System is one that provides 4Ms care to all older adults. To ensure that the 4Ms are being provided equitably, we encourage systems to specifically explore what disparities might exist and address them throughout their journey.[13] To start, identify what equity-related activities are already taking place in the organization and how older adults are represented in that work (which may be referred to as "diversity and inclusion"). Have a

conversation about how to align efforts to improve outcomes for older adults, especially at the intersection of race, ethnicity, language, sexual orientation, gender identity, and age.

Specifically, organizations can explore:

- What is happening internally to address systemic racism, ageism, and bias?
- How are older adults represented in conversations about existing inequities in care?
- What is your capability for reliable and accurate data collection and data stratification (e.g., by race, ethnicity, and language (REaL), sexual orientation and gender identity (SOGI), or other factors)?
- What does your organization already know about inequities based on stratification of outcomes by REaL and SOGI? How do those inequities affect older adults?
- What is the historical relationship between the organization and older adults belonging to groups that have been marginalized in your community?
- What is the experience at your organization of older adults belonging to groups that have been marginalized? Form connections with older adults with lived experience to solicit feedback on what is working well and less well.

Select an Office in Your Home Health Care Organization to Begin Testing

Once you identify where the 4Ms are currently in practice in the provision of home health care, select an office, CCN (CMS Certification Number), or territory (geographic region) in which to begin testing age-friendly interventions. Some home health care organizations have used or adapted readiness assessments, such as the Organizational Readiness for Implementing Change (ORIC) tool, to asses readiness for testing. Below are example prompts that Sutter Health used in their testing process to consider when selecting an office or CCN:

- People who work here are committed to implementing Age-Friendly Health System (AFHS) care.
    - People who work here feel confident that the organization can support people with informational technology resources (e.g., electronic health record documentation, data dashboards, reporting mechanisms) as they adjust to this change.
- People who work here feel confident that the organization can support people with communication resources (e.g., high quality formal and informal information sharing practices) as they adjust to this change.
- People who work here feel confident that there are strong relational connections (e.g., high quality formal and informal relationships, networks, and teams within the organization and with external collaborators) that support a culture of shared values, beliefs, and norms that will facilitate this change.

Assemble and Prepare a Team

Based on our experience, teams that include certain roles and/or functions are most likely to succeed (see Table 4). As you establish your team to begin testing age-friendly interventions, consider the following questions:

- Does the team represent a diversity of perspectives? Consider all the different roles within the provision of home health care that may be involved in practicing the 4Ms with older adults. Additionally, is the team representative of the race, ethnicity, culture, and language diversity of the older adult population?
- How do power dynamics affect the team? How might you ensure that all team members are able to actively participate in identifying and testing change ideas? Can you protect time for all team members to participate in the improvement process, including by providing coverage for care provision?

Key Points about What Matters

- The goal of asking What Matters is to understand and align care with each older adult's specific health outcome goals and care preferences, across settings of care.
- Health outcome goals relate to values and activities — for example, babysitting a grandchild, walking with friends in the morning, or volunteering in the community. They help motivate the individual to sustain and improve health. Health outcomes goals may change if there is a decline in health.
- Care preferences include the care activities (e.g., medications, self-management tasks, health care visits, testing, and procedures) that older adults are willing and able (or not) to do or receive.
- While advance care planning and end of life are important, What Matters extends to **all** care with older adults across their lifespan.

Table 4. Team Member Roles

Team Member	Description
An Older Adult and Care Partner	Older adults and their families or care partners bring critical expertise to any improvement team. They have a different experience with home health care than providers and can often identify key issues. We highly recommend that each team has at least one older adult and one family member/care partner (ideally more than one), or a way to elicit feedback directly from those individuals. Additional information about appropriately engaging older adults and care partners in improvement efforts can be found on in the IHI blog post Valuing Lived Experience: Why Science Is Not Enough, on the Institute for Patient- and Family-Centered Care website, and from the RUSH Caring for Caregivers program.[14]
Leader/Sponsor	This person champions, authorizes, and supports team activities, as well as engages senior leaders and other groups within the care setting to remove barriers and support implementation and scale-up efforts. Although they may not do the "on-the-ground" work, the leader/sponsor is responsible for: • Building a case for change that is based on strategic priorities and the calculated return on investment • Encouraging the improvement team to set goals at an appropriate level • Providing the team with needed resources, including staff time and operating funds; • Ensuring that improvement capability and other technical resources, especially those related to information technology (IT) and electronic health records (EHRs), are available to the team • Developing a plan to scale up successful changes from the improvement team to the rest of the organization.
Administrative Partner or Champion	This person represents the disciplines involved in the 4Ms and works effectively with clinicians, other technical experts, and leaders within the organization. We recommend that this role is fulfilled by the manager of the unit where changes are being tested because that individual likely can move nimbly to take necessary action, can make recommended changes, and is invested in sustaining changes that result in improvement.
Interprofessionals, Including Clinicians and Others Representing Disciplines Involved in the 4Ms	These individuals may include a physician, nurse practitioner, nurse, certified nursing assistant (CNA), recreational therapist, physical, occupational, or speech therapist, social worker, care manager, pharmacist, chaplain, dietary professional, environmental services worker, and/or others who represent the 4Ms in your context. We strongly encourage interprofessional representation on your team and urge you to enlist more than one clinical champion. These champions should have or be able to develop good working relationships with colleagues and be interested in driving change to achieve an Age-Friendly Health System. Consider professionals who are opinion leaders in the organization, whom others seek for guidance, who are close to the point of care, and who are not afraid to test and implement changes.
Others	• Improvement coach • Data analyst/EHR analyst • Finance representative

Step 2. Describe Care Consistent with the 4Ms

There are many ways to improve care for older adults. However, there is a specific set of key actions, summarized below, that touch on all 4Ms and dramatically improve care when implemented together (see Table 5). This list of actions is considered the gateway to your journey to becoming an Age-Friendly Health System. In Appendix C you will find a list of these key actions and ways to get started with each one in your setting, as well as additional tips and resources. Be sure to plan how you will document and make visible the 4Ms across the care team and settings.

Using the 4Ms Age-Friendly Care Description Worksheet (available at https://www.IHI.org/Initiatives/Age-Friendly-Health-Systems/Recognition), describe what it means to provide care consistent with the 4Ms. This worksheet helps you to assess, document, and act on the 4Ms as a set, while customizing the approach for your context. To be considered an Age-Friendly Health System, your system must engage or assess people age 65 and older for all 4Ms, document 4Ms information, and act on the 4Ms accordingly. As you test the 4Ms, you may make updates to your Care Description based on what you learn about the tools and methods that work best in your context.

Consider what you already know about inequities in access to care and supports and how those inequities might affect the ability for all older adults to receive 4Ms care in the manner you are describing. Where you have questions about equity, seek to understand through existing data and discussion with older adults and their caregivers from traditionally marginalized groups. This worksheet enables team members to integrate age-friendly best practices to assess, document, and act on the 4Ms together while also customizing those practices for your home health care setting. To be considered an Age-Friendly Health System, your care provider must engage or assess older adults for all 4Ms, document 4Ms information, and act on the 4Ms accordingly.

In this step, use the 4Ms Age-Friendly Care Description Worksheet (see Appendix B) to describe 4Ms care for the older adults you support.

Questions to consider:

- How does the current state of your organization's practices compare to the actions outlined in the 4Ms Age-Friendly Care Description Worksheet?
- Which of the 4Ms do you already incorporate? How reliably are they practiced?

  For example: Do you already ask and document What Matters, review for high-risk Medication use, screen for and follow up on delirium, dementia, and depression (Mentation), and screen for and follow up on Mobility for each older adult? If so, with what frequency and where are results documented and shared? Are there written policies and standards for these activities?

- Where are there gaps in 4Ms? What ideas does the team have that could help prioritize and fill the gaps? How can each team member role contribute to one or more of the 4Ms (e.g., administrator, medical director, physician, nurse, CNA, social worker, recreational therapist, nutritionist, environmental services staff, physical/occupational/speech therapist, chaplain)?

Key Points about Mobility

- The focus is on **ensuring early, frequent, and safe mobility**, not just preventing falls. While asking about falls is important, it is not sufficient.
- A mobility screen allows the care team to understand the strengths of the older adult and identify potential opportunities to assess and manage impairments that may reduce mobility.
- It's essential to support older adults in identifying and setting a daily mobility goal that aligns with What Matters to them.
- In the home, address the environmental hazards you can control for.

Set an Aim

Given your current state, set an aim for this initial effort that includes addressing the experience of inequities in care. An aim articulates what you are trying to accomplish — what, how much, by when, for whom. It serves as the focus for your team's work and enables you to measure your progress. Below is an aim statement template that requires you to think about the equitable reach of 4Ms. We suggest starting with what you want to accomplish in the next six months.

Aim Statement Template

By [DATE], [NAME OF ORGANIZATION] will articulate how it operationalizes 4Ms care and will have provided that 4Ms care equitably for [NUMBER] of patients 65+ years old

Step 3. Design or Adapt Workflows

After review of your system, you may discover many 4Ms practices already in place. These you can maintain, improve, and expand where necessary. You will likely also discover other ideas you still need to test and implement. The subsequent steps provide guidance for testing and implementing. The key is to ensure that these practices are reliable — happening every time in every setting for every older adult (and their caregivers).

In this guide, we use terms such as "screening," "assessment," and "staging" to describe the purpose of a particular tool or process. See Appendix G for definitions for these terms as they relate to Age-Friendly Health Systems.

In Appendix C you will find a list of key actions and ways to get started with each one in your home health care organizations, as well as additional tips and resources.

Examine workflows and test change ideas related to assessing and acting on the 4Ms to address known and suspected inequities in care for older adults from diverse populations and with diverse needs. To uncover inequities in access, begin by calculating the proportion of patients who access your programs stratified by race and ethnicity, as well as other factors relevant to your community. Compare that data to the overall census in your system and in the community. Where you see differences between those who access certain visits, programs or supports and the census in your system or community, seek to understand why.

You may have many key actions already in place. You can sustain, improve, and expand them where necessary. You may still need to test and implement other ideas. The key is to ensure that these practices are consistent and reliable — occurring every time in every setting for every older adult and, when appropriate, their care partners.

Examine workflows and test change ideas related to assessing and acting on the 4Ms to address known and suspected inequities in care for older adults from diverse populations and with diverse needs.

Table 5. Age-Friendly Health Systems Summary of 4Ms Key Actions for Home Health Care

Assess	Act On
Know about the 4Ms for each older adult in your care	**Incorporate the 4Ms into care delivery and document in the care plan**
Key Actions (to occur regularly or with change in condition):	
• Ask the older adult What Matters to them, including their health outcome goals and care preferences • Document What Matters and ensure that all team members have access to response • Identify and document the older adult's caregiver in the home • Review for high-risk medication use, polypharmacy, adverse drug events, adequate monitoring • Screen for delirium upon start of care; resumption of care; or upon change in condition • Screen for dementia upon start of care; resumption of care; or upon change in condition • Screen for depression upon start of care; resumption of care; recertification; or upon change in condition • Screen for mobility	• Align the care plan with What Matters • Deprescribe or do not prescribe high-risk medications and optimize all other medications • Manage manifestations of dementia consider futher evaluation; refer to community organizations for education and/or support • Identify and manage factors contributing to depression; educate older adults and caregivers • Identify and manage factors contributing to delirium; educate older adults and caregivers • Promote early, frequent, and safe mobility; refer to physical therapy (PT) when necessary • Address environmental hazards in the home

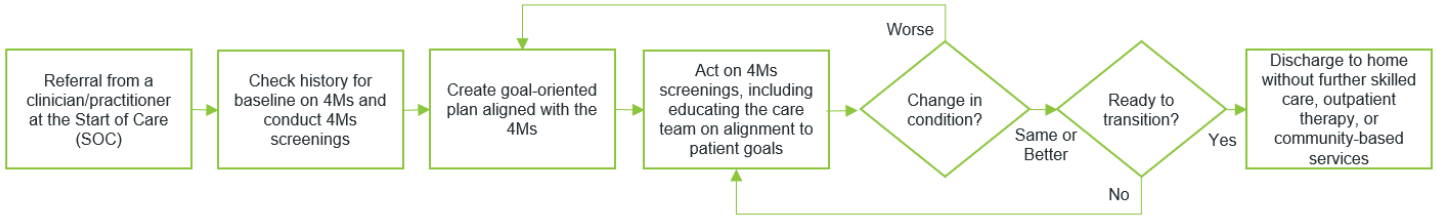
Supporting Actions:

- Use the 4Ms to organize care and focus on the older adult's wellness and strengths rather than solely on disease or reduced function.
- Integrate the 4Ms into care and existing workflows.
- Identify which activities you can stop doing to reallocate resources for the 4Ms.
- Document all 4Ms and consider grouping the 4Ms together in the clinical record and care plan.
- If your home health care provider is part of a health system, make the 4Ms visible across care teams and settings, including hospitals, primary care practices, nursing homes, and others.
- Form an interprofessional care team that reviews the 4Ms in regular huddles (or add this task to the mission of an existing interprofessional team).

- Educate older adults, care partners, all team members, and the community about the 4Ms.
- Align the 4Ms with community resources and supports as well as public health initiatives to achieve improved health outcomes across all settings.

Include the key actions above and description of age-friendly care in workflows. You may start with a high-level workflow like the example shown in Figure 4.

Figure 4. Age-Friendly Care Workflow Example for Home Health Care: Core Functions



Once you have developed your high-level workflow, in the space below each core function in the workflow, list ideas for how you will incorporate the 4Ms. Be specific about who will do what, where, when, how, and how it will be documented.

Outline what you still need to learn and identify the specific 4Ms key actions you will test (e.g., use the Timed Up & Go (TUG) Test or other evidence-based tool to evaluate mobility and fall risk; use a standardized checklist to identify high-risk medications). Consider use of a structured equity lens when evaluating potential change ideas. For ideas, review the questions in Table 1 of this piece: Weaving Equity into Every Step of Performance Improvement.

Step 4. Provide Care Consistent with the 4Ms

Learn as you move toward reliable 4Ms care. Begin to test the key actions with one older adult and their family or other caregivers as soon as you have notes for Step 2 (Describe Care Consistent with the 4Ms) and Step 3 (Design or Adapt Your Workflow). Do not wait to have your forms or EHR screens finalized before you test with one older adult. Use the Plan-Do-Study-Act (PDSA) Worksheet to plan your tests and learn more from them. Then, scale up your tests. For example:

- Apply your draft standard process and workflow first with one older adult. Can your team follow the steps? If not, why not?
- If necessary, modify the steps. Then, apply it with five older adults. What lessons do you learn from applying 4Ms care with these older adults? What impact does learning about all 4Ms have on care plans?

- If necessary, modify the steps. Then, apply with 25 older adults and keep going. Are you getting close to being able to use the process for every older adult you are aiming for? Are you getting positive results?

An example of a PDSA cycle that may help with testing and workflow can be found in Appendix D, along with a blank template.

Based on the inequities you have found in your data, identify adaptations needed to address inequities. Leverage existing outreach programs that serve older adults who experience barriers to accessing care or belong to groups that have been marginalized.

Step 5. Study Your Performance

How reliable is your 4Ms care? What impact does 4Ms care have on clinical or other outcomes? Here are basic approaches to measure and study performance using both qualitative data and quantitative data from your existing systems.

Observe and Seek to Understand (Qualitative Data)

Observe: Start with direct observation of your draft 4Ms Age-Friendly Care Description in action.

- Can your team follow the 4Ms Age-Friendly Care Description and successfully assess and act on the 4Ms with the older adults in your care?
- Do care plans reflect person-directed goal setting and 4Ms care?

Suggested timeline: In the first month for one office, CCN, or territory (geographic region), directly observe 4Ms care for at least one older adult each week. Then, for the next six months, observe 4Ms care for at least five older adults each month.

Ask the Team: At least once per month for several months during the testing period, ask the team two open-ended questions and reflect on the answers:

- What are we doing well to assess, act on, and document the 4Ms?
- What do we need to change to translate the 4Ms into more effective care?
- What do we need to address to ensure older adults are experiencing the 4Ms equitably?

Plan with the team how and when you will continue to use open-ended questions to reflect together on an ongoing basis.

Ask Older Adults and Care Partners: At least once in the first month during the testing period, ask one older adult and one care partner two open-ended questions and reflect on the answers:

- What went well in your care today?
- What could we do better to understand what age-friendly care means to you?

Next, in the second month of testing, ask five additional older adults the same questions. Plan with the team how and when you will continue to talk with older adults using open-ended questions on an ongoing basis. State where you will document the feedback received during these conversations. When identifying older adults to speak with, ensure you are connecting with older adults who represent the diversity in your organization and have a range of experiences.

Measure How Many Older Adults Receive 4Ms Care (Quantitative Data)

There are three options to start measuring older adult encounters that include 4Ms care. We recommend starting with Option 1 because it directs close attention to the 4Ms work and it is an easier way to collect the data than Option 2 (conducting retrospective chart reviews) or Option 3 (building a specific EHR report).

Option 1: Real-Time Observation (Recommended)

Use real-time observation and staff reporting of the work to tally your 4Ms counts on paper or electronically. An example might look like the chart in Figure 6.

Date	***4Ms Care according to our site description***						
	All 4Ms	**What Matters**	**Medications**	**Dementia**	**Depression**	**Delirium**	**Mobility**
Pt ID	if N, check details						
101	Y N	Y N	Y N	Y N	Y N	Y N	Y N
102	Y N	Y N	Y N	Y N	Y N	Y N	Y N
103	Y N	Y N	Y N	Y N	Y N	Y N	Y N
104	Y N	Y N	Y N	Y N	Y N	Y N	Y N
105	Y N	Y N	Y N	Y N	Y N	Y N	Y N
106	Y N	Y N	Y N	Y N	Y N	Y N	Y N
107	Y N	Y N	Y N	Y N	Y N	Y N	Y N
108	Y N	Y N	Y N	Y N	Y N	Y N	Y N
109	Y N	Y N	Y N	Y N	Y N	Y N	Y N
110	Y N	Y N	Y N	Y N	Y N	Y N	Y N
111	Y N	Y N	Y N	Y N	Y N	Y N	Y N
112	Y N	Y N	Y N	Y N	Y N	Y N	Y N
113	Y N	Y N	Y N	Y N	Y N	Y N	Y N
114	Y N	Y N	Y N	Y N	Y N	Y N	Y N
115	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Figure 6. Example of Real-Time Observation in Home Health Care

Option 2: Chart Review

If real-time observation is not feasible, consider a sampling strategy using chart review. Using a tally sheet like the example discussed in Option 1, review charts for evidence of 4Ms care. One approach to sampled chart review is outlined below.

- Randomly select 20 charts of older adults eligible for 4Ms care (i.e., those with whom you have tested or intended to provide 4Ms care) in a particular time period. If your home health care provider has fewer than 20 older adults in their care, complete chart review for all older adults for whom you intended to provide 4Ms care. Note: Care plan meetings during the time period may be a good opportunity to identify your sample.
- In the 20 sample charts, observe how many older adults received your described 4Ms care (noted as "C" in the calculation below).
- Calculate the approximate number of older adults receiving 4Ms care in the time period as follows:

> Estimated number of older adults receiving 4Ms care =
>
> (C ÷ 20) x Total number of older adults eligible for 4Ms care

Option 3: EHR Report

If you have an EHR, you may be able to run EHR reports, especially on assessment of the 4Ms, to estimate the number of older adults receiving 4Ms care in a particular time period. It may take a lot of effort to create a suitable report, so we do not recommend this option as your first choice.

However, for ongoing monitoring and improvement, organizations are encouraged to develop reports that show 4Ms performance; you may be able to request report development from your IT services while starting with Option 1 or 2.

Routine Meausment of 4Ms Care

The approaches above are aimed at getting your system to be able to count the number of older adults receiving 4Ms care which will allow you to submit your counts for Age-Friendly Health System—Committed to Care Excellence (Level 2) recognition and start collecting data on the overall reliability of the 4Ms in your care.

Systems should strive to have more comprehensive data on the reliability of the 4Ms in their care. More details on measures to consider can be found in Appendix F.

> See Appendix F for guidance on implementing reliable 4Ms age-friendly care.

Stratify Your Data

Based on your exploration in previous steps, you have hopefully discovered what capabilities exist in your system(s) to stratify data by current self-reported categories, such as race, ethnicity, and language (REaL), sexual orientation and gender identity (SOGI), and geography.

Teams that are new to stratification can start with stratifying one measure that is most reliably collected and work toward stratifying all 4Ms measures being collected.

Examine your stratified data to identify any gaps in care and explore what adjustments to your current processes are required to close these gaps and provide equitable access to 4Ms care.

Health equity requires that health systems stratify key performance measures by these factors to reveal disparities and provoke action to eliminate them. For Age-Friendly Health Systems, we encourage stratifying outcome measures for older adults using the Office of Management and Budget core race and ethnicity factors to identify disparities in patient care and experience. We also encourage participation in the Human Rights Campaign Healthcare Equality Index, which promotes LGBTQ patient-centered care. Lastly, systems can leverage other data collection efforts related to social determinants and geography to see what other population groups might need special focus to receive best possible care and support.

Step 5. Improve and Sustain 4Ms Care

Reminder: Integrating the 4Ms as a Cycle

While we present the steps as a sequence, in practice, Steps 2 through 5 are a cycle aligned with the PDSA method (see Figure 3 above). As you establish your 4Ms care, you may cycle through these steps many times over the course of several months in order to achieve reliability and sustainability over time. See Appendix D for an example of a PDSA cycle and a blank template.

To ensure equitable experience of the 4Ms, while working to fully embed the 4Ms into your care, adapt approaches and resources to different languages, literacy levels, sexual orientations, and cultures. Before widely or permanently implementing a change, test it with diverse older adults and modify as necessary to meet the needs of all who access care.

For example, do educational materials represent care relationships across different sexual orientations? Do providers who talk about health care proxies and wishes for care through the end of life understand the nuances of how these conversations may vary in different cultures? How can conversations be adapted to suit different cultural norms?

When considering the sustainability of your changes over time, use MOCHA (Measurement, Ownership, Communication, Hardwire the change, Assess the workload) to help identify areas for focus (see Table 7).

Table 7. MOCHA Questions for Sustainability of the 4Ms

Measurement	• What measures are we tracking that will allow us to know how reliable our 4Ms care is for older adults in our system? • How will we know what impact the 4Ms is having on key outcomes? • Who is responsible for ensuring that measures are tracked and monitored over time? • How are our measures being shared with leadership and staff involved in providing 4Ms care?
Ownership	• Who is the lead for the 4Ms in our system? Do they have what they need to support spread of the 4Ms over time? • Who is our leadership champion? How are they involved in supporting this work over time?
Communication	• How are we sharing what we learn about the 4Ms and their impact on care? • Do all staff who are involved in providing 4Ms care know about the advantages of providing 4Ms care? • Are we training new and current staff on how to assess and act on the 4Ms? • How are we communicating about our needs and successes at all levels in the system? • How are we communicating about the 4Ms to older adults?
Hardwire the change	• Are the 4Ms integrated into workflows? • Do the EHR and other key support tools reflect the 4Ms? • Have we integrated the 4Ms into regular huddles and care planning conferences to maximize impact? • Have we listed assessing and acting on the 4Ms as part of key responsibilities for relevant care roles?
Assess the workload	• Do we know what impact assessing and acting on the 4Ms has on the current workload of staff? • If we have added to responsibilities, have we adjusted other responsibilities as needed?

For more information about how to improve and sustain 4Ms care, please see the IHI white paper *Sustaining Improvement*.[15]

Appendix A: Process Walk-Through: Know the 4Ms in Your Home Health Care Organization

There are two key drivers to age-friendly care: knowing about the 4Ms for each older adult in your care ("assess") and incorporating the 4Ms into the plan of care and actual care delivery ("act on"). An Age-Friendly Health System aims to reliably assess and act on all of the 4Ms with all older adults. The initial objective is to understand where 4Ms care is currently happening and build on that work so that all 4Ms occur reliably for all older adults in the nursing home and across settings.

How do you already assess and act on each of the 4Ms in your setting?

One way to find out is to spend time on your home health care organization observing care. Here are some guiding questions:

- What are current activities and services related to each of the 4Ms? What processes, tools, and resources to support the 4Ms do we already have in place here or elsewhere? How are hospital, ambulatory, and/or nursing home partners engaged in promoting the 4Ms across settings?
- Where is the prompt or documentation for 4Ms available in the written records, EHR, care plan, or elsewhere for all clinicians and care team members? Is there a place to see the 4Ms (individually or together) that is easily accessible to all team members? Across settings?
- What experience do your team members have with the 4Ms? What assets do you already have on the team? What challenges have they faced? How have they overcome them?
- What internal or community-based resources do you commonly refer to and for which of the 4Ms? For which of the 4Ms do you need additional internal and/or community-based resources? Public health resources?
- Do your current 4Ms activities and services appear to be having a positive impact on older adults and/or care partners? Do you have a way to hear about and document older adults' experiences?
- Do your current 4Ms activities and services appear to be having a positive impact on clinicians and staff?
- What programs exist to support older adults related to the social determinants of health? How can they complement work on the 4Ms?
- What works well?
- What could be improved?

4Ms in Home Health Care	Specifically, Look for How Do We…	Current Practices and Observations • *List tools, assessment forms and checklists in current use* • *Describe how the use of these tools is monitored/measured by leaders* • *Describe current staff training*
What Matters Know and align care with each older adult's specific health outcome goals and care preferences, including all stages of life and across settings of care	• Ask each older adult What Matters most, document it, and share What Matters across the care team • Align the care plan with What Matters most to the older adult • Identify and document family in the home, caregiver, and/or document if no such individual exists	
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	• Review for high-risk medication use, ensure it's up to date and documented • Deprescribe or avoid high-risk medications, and document and communicate changes • Educate older adults, care partners, team members	
Mentation — Dementia Prevent, identify, treat, and manage dementia across settings of care	• Screen for dementia/cognitive impairment and document the results • Address behavioral and other manifestations of dementia; educate older adults and care partners; consider further evaluation and/or referrals as needed	
Mentation — Depression Prevent, identify, treat, and manage depression across settings of care	• Screen for depression and document the results • Identify and manage factors contributing to depression, refer for further evaluation as indicated	

4Ms in Home Health Care	Specifically, Look for How Do We…	Current Practices and Observations
Mentation — Delirium Prevent, identify, treat, and manage delirium across settings of care	• Screen for delirium upon start of care, resumption of care, and upon change in condition or as needed and document and act on the results • Identify and manage factors contributing to delirium, educate older adults and caregivers • Act to remove underlying cause(s) of delirium	
Mobility Ensure that each older adult moves optimally every day to maintain function and do What Matters	• Screen for mobility and document and act on the results • Promote early, frequent, and safe mobility; refer to PT when necessary • Address environmental hazards in the home	

Appendix B: 4Ms Goals and Age-Friendly Care Description Worksheet

Age-Friendly Health Systems is a movement of thousands of hospitals, practices, and nursing home communities working to ensure the best possible care for older adults. IHI recognizes organizations that have committed to practicing 4Ms care and have described 4Ms care for their setting.

Home Health Care Setting

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

Health System/Organization Name:

Care at Home Setting (if you are describing how the 4Ms are practiced across multiple practices or organizations, please list each practice/organization):

Key Contact (name, role, email, telephone, address/location):

Engagement with Age-Friendly Health Systems (Action Community, DIY pathway, etc.):

EHR platform (if any):

	What Matters	Medication	Mentation – Dementia	Mentation — Delirium	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 delirium 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.
Screen / Assess Please check the boxes to indicate items used in your care/care plans 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: View guiding questions from What Matters Toolkit. *Minimum requirement: 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 in older adults: ☐ Benzodiazepines ☐ Opioids ☐ Highly-anticholinergic medications (e.g. diphenhydramine) ☐ All prescription and over-the-counter sedatives and sleep medications ☐ Muscle relaxants	Check the tool used to screen for cognitive impairment for all older adults. ☐ Mini-Cog (screen) ☐ Brief Interview for Mental Status (BIMS) ☐ Short Portable Mental Status Questionnaire ☐ Other: _____ *Minimum requirement: At least one box must be checked. If only*	Check the tools used to screen for delirium: ☐ Confusion Assessment Method (CAM) ☐ Other: _____ *Minimum requirement: The first box must be checked. If only "Other" is checked, will review.*	Check the tools used to screen for depression: ☐ Patient Health Questionnaire (PHQ) - 2 ☐ Patient Health Questionnaire (PHQ) - 9 ☐ Geriatric Depression Scale (GDS) - short form ☐ Geriatric Depression Scale (GDS) ☐ Hamilton Depression Scale ☐ Other: _____	Check the tool used to screen for mobility limitations for all older adults. ☐ Timed "Up & Go" (TUG) ☐ Johns Hopkins High Level of Mobility (JH-HLM) ☐ Tinetti Performance Oriented Mobility Assessment (POMA) ☐ Any screening tools mandated by Federal regulation (such as OASIS)

	What Matters	Medication	Mentation – Dementia	Mentation — Delirium	Mentation — Depression	Mobility
		☐ Tricyclic antidepressants ☐ Antipsychotics ☐ Mood stabilizers ☐ Other: _____ *Minimum requirement: All eight boxes must be checked*	*"Other" is checked, will review.*		*Minimum requirement: At least one of the first five boxes must be checked. If "Other" is checked, will review.*	☐ Screening and assessment forms per physical therapy: _____ ☐ Other: _____ *Minimum requirement: One box must be checked. If screening/assessment is done by physical therapy, please identify the tool used. If only "Other" is checked, will review.*
Frequency	☐ Start of care (SOC) ☐ Recertification (REC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Other: _____	☐ Start of care (SOC) ☐ Recertification (REC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Upon discharge from organization	☐ Start of care (SOC) ☐ Recertification (REC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Other: _____	☐ Start of care (SOC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Upon discharge from organization ☐ Other: _____	☐ Start of care (SOC) ☐ Recertification (REC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Other: _____	☐ Start of care (SOC) ☐ Recertification (REC) ☐ Resumption of care (ROC) ☐ Upon significant change in condition (SCIC) ☐ Other: _____

	What Matters	Medication	Mentation – Dementia	Mentation — Delirium	Mentation — Depression	Mobility
	Minimum requirement: All four boxes must be checked.	☐ Other: _____ *Minimum requirement: All five boxes must be checked.*	*Minimum requirement: All four boxes must be checked.*	*Minimum requirement: All four boxes must be checked.*	*Minimum requirement: All four boxes must be checked.*	*Minimum requirement: All four boxes must be checked.*
Documentation Please check the box "EHR (electronic health record), care plan" or fill in the blank for "Other." Documentation should include goal setting and care plan. System should outline how clinicians find and review one another's notes to optimize communication.	☐ EHR ☐ Patient stated goals in plan of care ☐ Other: _____ *One box must be checked. If "Other," will review.*	☐ EHR ☐ Updated medication list in home ☐ Other: _____ *Minimum requirement: First two boxes must be checked*	☐ EHR ☐ Other: _____ *One box must be checked. If "Other," will review*	☐ EHR ☐ Other: _____ *One box must be checked. If "Other," will review.*	☐ EHR ☐ Other: _____ *One box must be checked. If "Other," will review*	☐ EHR ☐ Other: _____ *One box must be checked. If "Other," will review*
Act On Please describe how you use the information obtained from	☐ Align the care plan with What Matters most ☐ Identify and document family in	☐ Educate older adults and caregivers ☐ Medication reconciliation and	☐ Share results with older adults and caregivers ☐ Share results with prescriber	*If screen is positive, complete below. Must check three boxes.*	☐ Educate older adult and caregivers ☐ Share results with prescriber	☐ Report to prescriber and confer on next steps, including physical/occupational therapy

	What Matters	Medication	Mentation – Dementia	Mentation — Delirium	Mentation — Depression	Mobility
Screen/Assess to design and provide care.	the home, caregiver, and/or document if no such individual exists ☐ Other: _____ *Minimum requirement: One box must be checked.*	comprehensive medication review completed ☐ Updated/current medication list is provided to patient and/or caregiver ☐ Deprescribe (includes both dose reduction and medication discontinuation) ☐ Refer to _____ ☐ Other: _____ *Minimum requirement: At least the first three boxes must be checked.*	☐ Provide educational materials to older adult and caregivers ☐ Refer to community organization for education and/or support ☐ Refer to _____ ☐ Other: _____ *Minimum requirement: Must check three boxes.*	☐ Share results with older adults and caregivers ☐ Share results with prescriber ☐ Provide educational materials to older adult and caregivers ☐ Implement non-pharmacological interventions (such as ensuring safe home environment, sleep, hygiene, adequate hydration, etc). ☐ Other: _____	☐ Discuss use/prior use of anti-depressant with provider for the older adult ☐ Refer to _____ ☐ Other: _____ *Minimum requirement: First two boxes must be checked.*	☐ Screen for environmental hazards via home safety assessment ☐ Confirm older adult has personal adaptive equipment and knows how to use it safely ☐ Multifactorial fall prevention protocol (e.g., STEADI) ☐ Educate older adult and caregivers ☐ Partner with older adult and/or caregivers to promote a safe home environment ☐ 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

	What Matters	Medication	Mentation – Dementia	Mentation — Delirium	Mentation — Depression	Mobility
						☐ Other: ___________ *Minimum requirement: Must check first box and at least 3 of the remaining boxes*
Primary Responsibility Indicate if one care team member has primary responsibility/ accountability for acting on one or more of the 4Ms and for leading other clinicians or care partners in acting on the 4Ms. **If multiple team members are involved, check all that apply, and circle primary team member.**	☐ Registered Nurse ☐ Speech Therapist ☐ Physical Therapist ☐ Occupational Therapist ☐ MD/PA/Nurse Practitioner ☐ Other: ___________ *Minimum requirement: One role must be selected.*	☐ Registered Nurse ☐ Speech Therapist ☐ Physical Therapist ☐ Occupational Therapist ☐ MD/PA/Nurse Practitioner ☐ Other: ___________ *Minimum requirement: One role must be selected.*	☐ Registered Nurse ☐ Speech Therapist ☐ Physical Therapist ☐ Occupational Therapist ☐ MD/PA/Nurse Practitioner ☐ Other: ___________ *Minimum requirement: One role must be selected.*	☐ Registered Nurse ☐ Speech Therapist ☐ Occupational Therapist ☐ Physical Therapist ☐ MD/PA/Nurse Practitioner ☐ Licensed Clinical Social Worker / Medical Social Worker ☐ Other: ___________ *Minimum requirement: One role must be selected.*	☐ Registered Nurse ☐ Speech Therapist ☐ Physical Therapist/Occupational Therapist ☐ Licenced Clinical Social Worker / Medical Social Worker ☐ MD/PA/Nurse Practitioner ☐ Other: ___________ *Minimum requirement: One role must be selected.*	☐ Registered Nurse ☐ Speech Therapist ☐ Physical Therapist/Occupational Therapist ☐ Licenced Clinical Social Worker / Medical Social Worker ☐ MD/PA/Nurse Practitioner ☐ Other: ___________ *Minimum requirement: One role must be selected.*

Appendix C: Key Actions and Getting Started with Age-Friendly Care

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources[2]**
What Matters Ask the older adult What Matters, including specific health outcome goals and care preferences	If you do not have existing questions to start this conversation, try the following and adapt as needed: *"What do you most want to focus on for_____ (fill in health problem) so that you can do_____ (fill in desired activity) more often or more easily?"* [16,17,18] For older adults with advanced or serious illness, consider: *"What are your most important goals if your health situation worsens?"* [19]	**Tips** • This action focuses clinical encounters, decision making, and care planning on What Matters most to the older adults. • Consider segmenting your population by healthy older adults, those with chronic conditions, those with serious illness, and individuals at the end of life. How you ask What Matters of each segment may differ. • Consider starting these conversations with *who* matters to the person. Then ask them what their plans are related to life milestones, travel plans, birthdays, and so on in the next six months to emphasize, "I matter, too." Once "who matters" and "I matter, too" are discussed, then *what* matters becomes easier to discuss. The What Matters Most letter template (Stanford Letter Project) can guide this discussion. • Responsibility for asking What Matters can rest with any member of the care team; however, one person needs to be identified as responsible to ensure it is reliably done. • You may decide to include family or care partners in a discussion about What Matters; however, it is important to also ask the older adult individually. • Ask people with dementia What Matters. • Ask people with delirium What Matters at a time when delirium symptoms are minimal or absent.

[2] Many free tools and resources are included throughout this Appendix and Guide; however, some may have associated costs. Contact the owner of the resource for more information about pricing.

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources**[2]
		Resources • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • The Conversation Project and "Conversation Ready" • Patient Priorities Care • Serious Illness Conversation Guide • Stanford Letter Project • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council) • End-of-Life Care Conversations: Medicare Reimbursement FAQs • Respecting Choices COVID-19 Resources (for having conversations with older adults when planning care for COVID-19) • Caring for Caregivers (C4C) Across the US - Center for Excellence in Aging at Rush University • My Health Checklist • NIH Taking Care of Yourself: Tips for Caregivers • Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices We recognize that members of different groups have diverse needs. There are resources available that are specific to various communities. For example, the following resources can help to integrate an LGBTQ lens into this action: • Caregiving in the LGBT Community • Create Your Care Plan • My Personal Directions for Quality Living • Advocating for Yourself and Others • Supporting LGBT People Living with Dementia • Issue Brief: LGBT People and Dementia • Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies
What Matters	Documentation can be on paper, on a whiteboard (following privacy	**Tips**

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources[2]**
Document What Matters	guidelines), or in the EHR, where it may be accessible to the whole care team across settings.[20]	• Consider documentation of What Matters to the older adult on paper or in an electronic format that they can have and review. • Identify where health and health care goals and priorities can be documented and available across care teams and settings. • Review What Matters documentation to ensure that goals/plans are specific to each person (i.e., watch out for generic or the same answers across all people, which suggests a deeper discussion of What Matters is warranted). **Resources (also see resources in the section above)** • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council) • CMS Resources on Current Emergencies • OpenNotes Shared Access Toolkit: Clinicians & Health Systems for caregiving proxy access in the electronic health record (EHR)
Medication Review for high-risk medication use	Specifically, look for: • Benzodiazepines • Opioids • Highly anticholinergic medications (e.g., diphenhydramine) • All prescription and over-the-counter sedatives and sleep medications • Muscle relaxants • Tricyclic antidepressants • Mood stabilizers • Antipsychotics[21,22,23]	**Tips** • A comprehensive approach to medication optimization with input from multiple team members should be part of a Quality Assurance Performance Improvement (QAPI) plan. • Include input and insights from home health aides — they spend the most time with older adults. • If your team decides to limit the number of medications to focus on, identify those most frequently dispensed by your home health care organization, or those for which there is a champion to deprescribe. Include pharmacist, medical director, nurse leader(s), and social worker if possible. **Resources** • American Geriatrics Society 2023 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults • AGS 2023 Beers Criteria Pocketcard (or most recent version) • MedSafer in LTC: electronic deprescribing tool • TaperMD tool to help optimize medication regimens

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources[2]**
		STOPP (Screening Tool of Older Persons' Prescriptions) and START (Screening Tool to Alert to Right Treatment)
Mentation — Dementia Assess for cognitive challenges (dementia or other conditions such as mild cognitive impairment (MCI))	If you do not have an existing tool, try using the Mini-Cog©[24]	**Tips** • Reduce any stress related to cognitive screening. For example, you could say, "I'm going to check your brain or cognitive health like we check your blood pressure, or your heart and lungs." • Emphasize an older adult's strengths when screening and document them so that all providers understand the person's baseline cognitive status. • If the older adult has a sudden change in cognition, consider and rule out delirium. **Resources** • Saint Louis University Mental Status (SLUMS) Exam • Montreal Cognitive Assessment (MoCA)
Mentation — Depression Assess for depression	If you do not have an existing tool, try using the Patient Health Questionnaire – 2 (PHQ-2).[25] Consider the PHQ-9 (longer screening tool).	**Tips** • Conduct the interview in private setting, eliminating extraneous distractions such as radio and TV. • Place yourself at eye level with older adult. Speak clearly using a calm tone of voice. • Interact with the older adult in their preferred language or offer an alternative such as writing or pointing. • Explain the reason for the assessment before beginning and seek consent from the older adult before beginning **Resources** • Patient Health Questionnaire – 9 (PHQ-9) • Geriatric Depression Scale (GDS) and GDS: Short Form to assess for depression in individuals who are living with dementia or other cognitive challenges

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources[2]**

Mentation — Delirium
 	
Screen for delirium at the start of care, resumption of care, and/or upon significant change in condition
	If you do not have an existing tool, try using the Confusion Assessment Method (CAM) or Ultra-Brief 2-Item Screener (UB-2).[26,27]	**Tips**
		• Decide on the tool that best fits your older adult population and your team's approach.
		• Be aware that low prevalence rates of delirium before the 4Ms are in place may indicate inaccurate use of a screening or assessment tool, or failure to reliably screen/assess.
		• It is critical to use any tool only as instructed and to do ongoing training (annual competency and orientation for new staff) to make sure it is being used correctly.
		• Ask questions in a way that emphasizes older adults' strengths (e.g., "Please tell me the day of the week" rather than "Do you know what day it is today?").
		• Educate family/care partners on the signs of delirium and enlist their support to alert the care team to any changes as soon as they notice them. Ask them if the older adult seems "like themselves."
		• Document mental status in the chart to measure changes.
		• Until ruled out, consider a change in mental status to be delirium and raise awareness among care team and family/care partners about the risk of delirium superimposed on dementia.
		• Delirium can and often does occur on top of existing dementia, and it can be treated and reversed.
		• Note: Delirium has an underlying medical cause and is preventable and treatable in most cases. Care teams need to:
		  • Confer with interprofessional team and care partners to remove or treat underlying cause(s)
		  • Restore or maintain function and mobility
		  • Understand behaviors that could be related to underlying delirium
		  • Prevent delirium complications
		
		Resources
		• CAM and its variations
		• Nursing Delirium Screening Scale (Nu-DESC)
		• AGS CoCare®: HELP program: Related Age-Friendly Resources
		• American Delirium Society

Mobility	If you do not have an existing tool, try using Timed Up & Go (TUG).[28,29]	**Tips**

Assess: Know about the 4Ms for Each Older Adult in Your Care		
Key Actions	**Getting Started**	**Tips and Resources[2]**
Screen for mobility limitations, environmental hazards, indications for a physical therapy (PT) and/or occupational therapy (OT) referral	Or, try observing the Up & Go without timing to assess mobility and determine what supports are needed.	• Older adults may be embarrassed or worried about having their mobility screened. • Underscore that a mobility screen allows the care team to know the strengths of the older adult, and potential opportunities to improve weak areas. • Focus on how assessing mobility can lead to interventions to make their home safer and to prevent falls or injuries. • Incorporate mobility into everyday activities, such as walking to the dining room or to activities with or without assistance, based on mobility assessment. • Co-design a process with your team to follow up if screening is positive. **Resources** • Stopping Elderly Accidents, Deaths, & Injuries (STEADI) • Short Physical Performance Battery (SPPB) and Gait speed • Performance-Oriented Mobility Assessment/Tinetti Mobility Test • 4-Item Dynamic Gait Index (DGI) • Banner Mobility Assessment Tool • Functional Independence Measure (FIM)

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**
What Matters Align care delivery and care plan documentation with What Matters	Incorporate What Matters into the goal-oriented plan of care and align the care plan with the older adult's goals and preferences[30,31,32] (i.e., What Matters).	**Tips** • Health outcome goals are the activities that matter most to an individual, such as playing with a grandchild, walking with friends in the morning, or continuing to work as a teacher. Health care preferences include the medications, health care visits, testing, and self-management tasks that an individual is able and willing to do. • When you focus on the person's priorities, Medication, Mentation, and Mobility often come up so the person can do more of What Matters. • Consider how care from the home health care organization can be aligned with What Matters. • Consider What Matters to the older adult when making discharge plans.

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**
		• Use What Matters to develop the care plan and navigate trade-offs. For example, you may say, "There are several things we could do, but knowing what matters most to you, we could…" • Use the person's priorities (not focused on diseases) in communicating, decision making, and assessing benefits. • Use collaborative conversation and motivational interviewing;[33,34] agree there is no single answer, and brainstorm alternatives together. For example, you may say, "I know you don't like the CPAP mask, but are you willing to try it for two weeks to see if it helps you be less tired, so you can get back to volunteering, which you said was most important to you?" • Care options likely involve input from many disciplines (e.g., physical therapy, social work, community organizations, behavioral health, and others), as well as care partners in some cases. **Resources** • "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults • Patient Priorities Care • Serious Illness Conversation Guide • "What Matters to You?" Instructional Video and A Guide to Having Conversations about What Matters (BC Patient Safety & Quality Council) • Shared Access Toolkit: Clinicians & Health Systems
Medication Deprescribe or do not prescribe high-risk medications**	Consider avoiding or deprescribing the high-risk medications listed below. • Benzodiazepines • Opioids • Highly anticholinergic medications (e.g., diphenhydramine) • All prescription and over-the-counter sedatives and sleep medications	**Tips** • These medications, individually and in combination, may interfere with What Matters, Mentation, and safe Mobility of older adults because they may increase the risk of confusion, delirium, unsteadiness, and falls.[40] • Deprescribing includes both dose reduction and medication discontinuation. • Deprescribing is a person-centered approach, involving shared decision making, close monitoring, and compassionate support. • When possible, avoid prescribing high-risk medications (prevention); consider changing order sets to change prescribing patterns (e.g., adjust/reduce doses, change medications available). You may work with your PharmD or pharmacy consultant on policy and procedure changes. • Your home health care organization should have dementia, delirium, falls prevention/mobility promotion and management protocols that include guidance to avoid and minimize use of high-risk medications.

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**

	• Muscle relaxants
	• Tricyclic antidepressants
	• Mood stabilizers
	• Antipsychotics[35,36,37,38]
	
	If the older adult takes one or more of these medications, discuss any concerns the person may have, assess for adverse effects or interactions, and discuss deprescribing with the older adult.[39]
		• Offer nonpharmacological options to support sleep and manage pain.
		• Remove medications the older adult can stop taking upon discharge.
		• Print a medication list as part of standard check-out steps during care transitions and ensure that the older adult and family/care partners understand what the medications are for, how to take them, why they are taking them, and how to monitor whether they are helping or possibly causing adverse effects.
		• Review medication names to avoid duplication or confusion with generic and trade names.
		• Inform the person's ambulatory care clinicians of medication changes throughout the stay and upon discharge from the facility.
		• Consult pharmacist (PharmD) to assist with medication optimization approaches.
		• Educate patients and caregivers on the proper use of medications, potential side effects, and the importance of adherence to prescribed regimens. This education should be tailored to the specific needs and understanding of the older adult.
		• When instituting an age-friendly approach to medications:
		  ○ Identify who on your team will be the champion of this "M." The champion does not have to be a pharmacist, but it is vital to have a pharmacist or primary care clinician, as well as the older adult, work on the plan.
		  ○ Review your setting or system's data, if possible, to identify medications that may be high risk (e.g., anticoagulants, insulin, opioids) or potentially inappropriate (e.g., anticholinergics, sedating medications).
		  ○ Determine the goal(s) with respect to medication(s) identified in the previous step.
		  ○ Conduct a series of PDSA cycles to achieve the goal(s).
		
		Resources
		• deprescribing.org
		• How to implement deprescribing into clinical practice
		• Deprescribing and Medication Optimization Overview
		• Alternative Medications for Medications Included in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug–Disease Interactions in the Elderly Quality Measures
		• HealthinAging.org provides expert health information for older adults and caregivers about critical issues we all face as we age.

Mentation	Identify older adults that may have self-neglect or safety issues.	**Tips** • If there is presence of self-neglect or safety issues, work with the older adult, prescriber, caregiver, and others to offer supportive services such as home health aides, homemaker, or companion services

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**
		• Provide older adults with easily accessible resources, including hotlines for mental health crises and suicide prevention. • Recognizing and Acting on Mentation Concerns • Instructional video for Caregivers by AARP • Mitigate the risk of safety and/or violence in the home associated with the possession of firearms • Gun Safety for the older adult
Mentation — Dementia	Share test and evaluation results with the older adult and care partners. Assess for modifiable contributors to cognitive challenges. Consider further diagnostic evaluation if appropriate. Follow current guidelines for management of dementia and related behavioral manifestations of distress. Provide educational materials to the older adult and care partners. Consider referring the older adult, care partners to supportive resources, such as the Alzheimer's Association.[41]	**Tips** • Know about and refer older adults and their care partners to local organizations and resources to support them with education and/or guidance. • Include family members and/or care partners if/when appropriate. They may provide a source of information and support. • Consider assessing and managing care partner burden. • If a memory disturbance is found, avoid medications that may worsen cognitive health. • If there is a diagnosis of dementia, include it on the problem list. If not, include any cognitive changes. • Do not prescribe medications that can exacerbate cognitive limitations, such as benzodiazepines, antipsychotics, or anticholinergics. • Older adults with dementia will be at high risk of delirium, especially in a new setting, so educate family and providers on delirium prevention. Review sections and resources on delirium. **Resources** • Alzheimer's Association • Zarit Burden Interview (for caregivers) • CMS National Partnership to Improve Dementia Care in Nursing Homes
Mentation — Depression Identify and manage factors contributing to depression	Identify and manage factors that contribute to depressive symptoms, including sensory limitations (vision, hearing), social isolation,	**Tips** • Educate the older adult and care partner (if appropriate) about depression in older adults. • Recognize social isolation as a risk factor for depression and identify resources that support social connections.

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**
	losses of aging (job, income, societal roles), bereavement, and medications. Consider the need for counseling and/or pharmacological treatment of depression or refer to a mental health provider if appropriate.	• Include technology solutions such as platforms that support visual and audio communication (e.g., FaceTime, Zoom, Skype). **Resources** • Crosswalk: Evidence-Based Leadership Council Programs and the 4Ms
Mentation — Delirium Orient older adults to time, place, and situation if and when appropriate**	Share the evaluation results with the prescriber, older adult, and their care partners.	**Tips** • For older adults with dementia and superimposed delirium, consider gentle re-orientation or use of orienting cues; avoid repeated testing about orientation if the older adult appears confused or overwhelmed.[42] • Assess each person individually and evaluate whether re-orientation is helpful or not. • Consult your organization's delirium prevention and management protocol. • Identify environmental and person-centered approaches to orienting older adults as appropriate. • Meet the person "where they are" — do not try to correct a older adult who believes it is a much earlier time or that their parent needs to visit. Use techniques such as distraction or diversion, a walk inside or outside, looking through favorite picture books, listening to music and dancing, etc. • Train staff in recognizing behavior as a form of communication for older adults with a pre-existing cognitive impairment or dementia, and use non-drug approaches to managing behavior such as the DICE Approach (Describe, Investigate, Create, Evaluate), TA-DAA approach (tolerate, anticipate, don't agitate, and ambulate), and others. • Delirium may occur on top of existing dementia. If it occurs, potential causes of delirium (such as constipation, dehydration, illness, medications, and others) should be assessed and treated with best practices, including avoiding medication use.
Mentation — Delirium Ensure older adults have their personal adaptive equipment**	Incorporate routine intake and documentation of each older adult's personal adaptive equipment.	**Tips** • Personal adaptive equipment includes glasses, hearing aids, dentures, canes, wheelchairs, and walkers. • Your organization's delirium prevention and management protocol should include helpful interventions.

Act On: Incorporate the 4Ms into Care Delivery and Document in the Care Plan		
Key Actions	**Getting Started**	**Tips and Resources**
		• Confirm need for personal adaptive equipment with care partners. • Assess for mobility aid needs that may be different during the hospital stay than at home (e.g., using a cane or walker in the hospital that they do not usually use).
Mentation — Delirium Prevent sleep interruptions; use non-pharmacological interventions to support sleep**	Try using the Confusion Assessment Method (CAM) upon the start of care	**Tips** • Nonpharmacological sleep aids include earplugs, sleeping masks, muscle relaxation such as hand massage, posture and relaxation training, white noise and music, and educational strategies. • Your delirium prevention and management protocol should include non-pharmacological sleep support. • Make a sleep kit available for order in the EHR or written record. • Engage care partners to support sleep with methods that are familiar to and effective with the older adult.

Mobility
 	
Ensure early, frequent, and safe mobility**[43,44,45]
	Identify, set, and meet a daily mobility goal developed with or by each older adult.
	
	Manage impariments that reduce mobility (e.g. pain, balance, gait, strength)
		Tips
		• Assess and manage impairments that reduce mobility, for example:
		  ○ Manage pain
		  ○ Assess challenges with strength, balance, or gait (using Timed Up & Go or a similar assessment)
		  ○ Remove catheters, IV lines, telemetry, and other tethering devices as soon as possible
		  ○ Avoid physical and chemical restraints
		  ○ Avoid sedatives and drugs that immobilize older adults in their home
		  ○ Ensure that glasses and hearing aids are in use
		• Refer to physical therapy for interventions to help with balance, strength, gait, gait training, or an exercise program if needed. Consider referral to occupational therapy.
		• Use a white board to document daily mobility goals displayed in the home.
		• Your delirium prevention and management protocol or falls prevention protocol should address and encourage mobility.
		• Engage the older adult and care partners directly by offering exercises that can be done at home without health care team present.

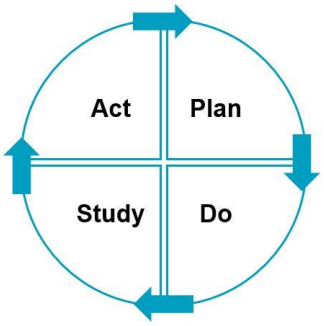
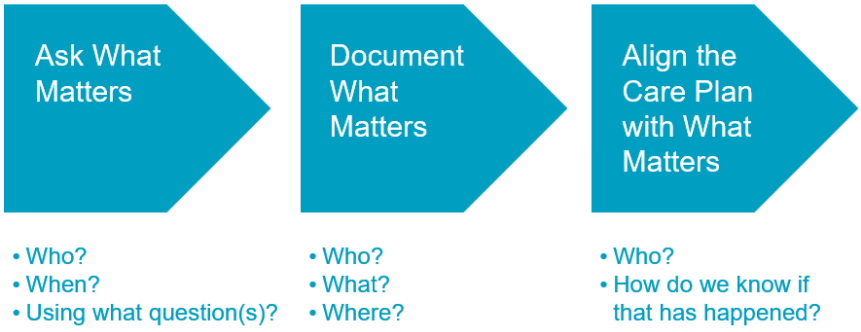
Additional Resources for Home Health Care:

- CMS Outcome and Assessment Information Set OASIS-E1 Manual
- CMS OASIS-EI All Item Assessment
- The Ultimate Guide to OASIS in Home Health Care: Everything You Need to Know
- CDC updates and simplifies respiratory virus recommendations
- CDC Updated COVID Guidelines

**These activities may also help to prevent delirium[46] and falls.

Appendix D: Sample PDSA Cycles for Age-Friendly Care

Example PDSA Worksheet: Testing Asking What Matters with Older Adults

<table>
<tr><td>Plan-Do-Study-Act Record</td><td>NAME OF HOME HEALTH CARE ORGANIZATION: Fairview Home Health
NAME OF PERSON COMPLETING FORM: Erin Rush, RN
DATE: February 1, 2025</td></tr>
<tr><td rowspan="2"> 
</td><td>Change Idea to ____develop or _X_ test or ____ implement</td></tr>
<tr><td>Description:
Cycle 1: Test a What Matters conversation with a home health care recipient .
Essential Ingredients
 
</td></tr>
<tr><td colspan="2">PLAN:</td></tr>
<tr><td colspan="2">Questions: What do we want to know?</td></tr>
<tr><td colspan="2">• What is it like for home health care providers to ask a different What Matters question during care?
• What new will be learned from the revised What Matters conversation and how will it affect care plans?</td></tr>
<tr><td colspan="2">Predictions: What do we think will happen?</td></tr>
<tr><td colspan="2">• Home health care providers can incorporate a new What Matters conversation into visists with older adults.
• Home health care providers will learn something useful from What Matters conversations relevant to care planning.</td></tr>
</table>

Plan for the change or test: Who, What, When, Where. What are we going to do to make our test happen?

List the tasks necessary to complete this test (What)	Person responsible (Who)	When	Where
Orient Evan (nurse) to this test	Erin	Monday morning	4 South
Select older adult for test	Erin and Evan	Monday morning	4 South
Ask older adult, "What is most important to you related to what you can do at home?"	Erin and Evan	Monday	TBD
Debrief test and complete PDSA cycle	Erin and Evan	Tuesday morning	4 South

Plan for data collection: Who, What, When, Where. How will we compare predictions to actual?

Erin and Evan to meet the next day to debrief test, capture what happened, impressions, how that compared to predictions, next steps.

DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened.

- Evan asked 1 and then 4 more older adults — went beyond testing with just 1 person!
- Some answers were very health-/condition-related (e.g., a person with shortness of breath/cough stated, "I just want my cough to be better and to be able to breathe").
- Other answers were more related to quality of life, for example:
  - A person being treated for stroke, who is a performance artist, shared a video of performance and indicated What Matters is to be able to return to performing.
  - A person with multiple falls wants to be able to stand to cook again.

STUDY: Complete data analysis; summarize what was learned; compare what happened to predictions above.

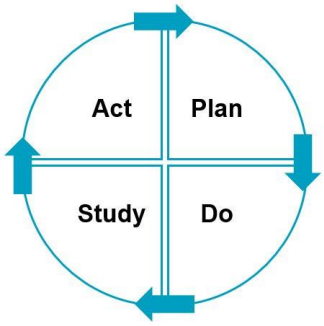
- Asking a single question is not sufficient. Need the opportunity for follow-up questions and listening. For example: A short-term, post-acute person with heart failure and arthritis has an immediate goal to reduce swelling in her legs. Further probing revealed a desire to stay in her home and be able to cook to avoid delivered salty foods and to avoid rehospitalization. Possible solution: Consider homemaker assistance, nutrition coaching.
- Evan regularly engages people in conversations about care goals but this question allowed for a conversation more related to lifestyle goals that supported care planning in other areas.
- Worthwhile if there is time for follow-up (not just one question and one answer in 30 seconds).
- No one responded with goals or needs that could not be addressed somehow in the care plan.
- Asking a What Matters question helped Evan get to know the client better and form a stronger relationship.
- There was a lack of clarity on what to do with the information learned from the What Matters conversation (e.g., how to document, how to share).
- Still have a concern about not knowing what to do if a person expresses a need or goal beyond the specific health condition or issues that the care provider is able to adress.

ACT: Are we ready to make a change? Plan for the next PDSA cycle.

Test again. Questions to explore through more testing include:

- Is it better to ask the What Matters question at the beginning or end of an interview/planned conversation with the client?
- How can we get at What Matters for our clients with cognitive impairment?
- Where is the best place to document the information from the What Matters conversations?
- Are the multidisciplinary huddles the best place to discuss what's learned from What Matters engagements?
    - Do we need to coordinate our engagement about What Matters? Nurses could be asking variants of What Matters.

Blank PDSA Worksheet

<table>
<tr><td>Plan-Do-Study-Act Record</td><td>NAME OF HOME HEALTH CARE ORGANIZATION:
NAME OF PERSON COMPLETING FORM:</td></tr>
<tr><td rowspan="2"> 
</td><td>Change Idea to ____develop or ___ test or ____ implement</td></tr>
<tr><td>Description:
Essential Ingredients
Ask What Matters
• Who?
• When?
• Using what question(s)?
Document What Matters
• Who?
• What?
• Where?
Align the Care Plan with What Matters
• Who?
• How do we know if that has happened?</td></tr>
<tr><td colspan="2">PLAN:</td></tr>
<tr><td colspan="2">Questions: What do we want to know?</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Predictions: What do we think will happen?</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Plan for the change or test: Who, What, When, Where. What are we going to do to make our test happen?			
List the tasks necessary to complete this test (What)	**Person responsible (Who)**	**When**	**Where**

Plan for data collection: Who, What, When, Where. How will we compare predictions to actual?
DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened.
STUDY: Complete analysis of data; summarize what was learned; compare what happened to predictions above.
ACT: Are we ready to make a change? Plan for the next cycle.

Appendix E: Implementing Reliable 4Ms Age-Friendly Care

A key goal is to reliably integrate the 4Ms into the way you provide care for every older adult, in every setting, every time.

How will you know that 4Ms care, as described by your site, is reliably in place?

The best way is to observe the work directly, using the 4Ms Age-Friendly Care Description Worksheet (see Appendix B) as an observation guide. Another way is to review charts to confirm completeness of 4Ms documentation and alignment of care team actions with information obtained in assessment. Note that you only need a handful of charts to tell you that your 4Ms performance is not at a high level (say, 95 percent or higher).[47] For example, if you see three instances of incomplete 4Ms care in a random sample of 10 charts, you have strong evidence that your system is not performing in a way that 95 percent or more of older adults are experiencing 4Ms care.

If an outside evaluator visited your care setting, they might also look for several kinds of evidence that your site has the foundation for reliable 4Ms care, including the following:

- If they ask five staff members, those staff members use the same explanation for WHY your site implements the 4Ms.
- If they ask five staff members, those staff members use the same explanation for HOW your site implements the 4Ms.
- Staff at your site have documentation for the 4Ms; they can access the 4Ms Age-Friendly Care Description and additional standard supporting operating procedures, flowcharts, and/or checklists.
- Training/orientation introduces new staff to the 4Ms work.
- Job description(s) outline elements of the 4Ms work as appropriate to the role(s).
- Performance evaluation refers to the 4Ms work.

Evaluators would also expect to learn about regular observation of 4Ms care by site supervisors and leaders who seek to understand and work with staff to remove barriers to reliable 4Ms care.

Appendix F: Measuring the Impact of 4Ms Age-Friendly Care

An age-friendly measurement dashboard can help your home health care organization understand the impact of the team's efforts to reliably provide 4Ms care to older adults.

The tables below list the outcome and process measures that IHI identified with prototyping teams to help ome health organizations track the impact of 4Ms age-friendly care. These measures were considered feasible and realistic to prototyping teams and align to existing OASIS requirement where applicable.

Additional Data Stratification

We recognize the persistence of important differences in treatment and health outcomes associated with race, ethnicity, gender, geography and other social factors. Health equity requires that home health organizations stratify data for key performance measures by these factors to reveal disparities and incentivize action to eliminate them. For organizations aiming to provide reliable 4Ms age-friendly care, we encourage stratifying outcome measures for older adults using the Office of Management and Budget core race and ethnicity factors to identify disparities in older adult care and experience alongside other demographic factors available in your records.

The tables below provide a breakdown of suggested measures, including Tables 9 and 10 for detailed breakdown.

Table 8. Overview of Measures for the 4Ms in Home Health

Process Measures	Outcome Measures
% of older adults assessed for all 4Ms % of older adults with what matters documented (in chart or other location visible to care team) % of older adults screened for high-risk medication use % of older adults on high risk medications referred to clinician for review % of older adults on any of the targeted medications % of older adults screened for delirium % of older adults screened for cognitive impairment % of older adults screened for depression "Act on" for mentation % of older adults screened for mobility % of older adults with a documented mobility goal or care plan added related to mobility improvement	Rehospitalization during the first 30 days of home health Rate of emergency department (ED) visits Patient experience/What Matters Act on Change in mobility

Process Measures

Table 9. Overview of Process Measures for the 4Ms in Home Health

Measure	Denominator	Numerator	Notes
% of older adults assessed for all 4Ms	All patients 65 years and older in the population considered to be patients of the organization who have a home visit during the measurement period	Patients in the denominator who have been assessed for all 4Ms as per the 4Ms description approved for the setting of care.	This measure is a composite of the patient who are in the numerator for each of the assessment measures below for each M. Organizations should focus on the regions/territories or offices currently implementing the 4Ms for this and the following measures
% of older adults with what matters documented (in chart or other location visible to care team)	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been assessed for what matters at start of care, recertification, resumption of care, and on change in condition, and had it documented in the common record.	The documentation of what matters in the chart is an easier measure to be tracked at scale from electronic records. Systems are strongly encouraged to pair this population level measure with periodic chart audit to insure that the “assess” and “act on” of what matters aligns with the spirit of the 4Ms. Systems should pair the monitoring of the “assess” of what matters with a patient reported measure that provides insight into if what matters was “acted on” from the patient perspective. Options are presented in the outcome measure section under patient experience.
% of older adults screened for high-risk medication use	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been screened for high medications at start of care, recertification, resumption of care, and on change in condition, as per the 4Ms care description and had that documented in the common record	
% of older adults on high risk medications referred to clinician for review	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period and were flagged for having a current prescription for a high risk medication	Patients in the denominator who have been referred for clinician of pharmacist medication review.	Systems are encouraged to complement this measure with other measures that reflect organizational policies related to medication education and review such as a medication management care plan or other standard process.

% of older adults on any of the targeted medications	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have a current prescription for a high risk medication as per the 4Ms care description.	
% of older adults screened for delirium	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been screened for delirium at start of care and on change in condition as per the 4Ms care description and had that documented in the common record.	
% of older adults screened for cognitive impairment	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been screened for cognitive impairment at start of care, recertification, resumption of care, and on change in condition as per the 4Ms care description and had that documented in the common record.	Patients who refuse the screen with documentation of refusal can be excluded from the denominator. Patients who have a positive screen for delirium should have their cognition screen deferred until delirium has been resolved and therefore can be excluded from the denominator until delirium is resolved.
% of older adults screened for depression	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been screened for depression at start of care, recertification, resumption of care, and on change in condition as per the 4Ms care description and had that documented in the common record.	Exclusions: Patients with active diagnosis of depression or bipolar disorder; patients who refuse the screen with documentation of refusal. Patients who have a positive screen for delirium should have their depession screen deferred until delirium has been resolved and therefore can be excluded from the denominator until delirium is resolved.
“Act on” for mentation	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period and were screened as requiring follow-up for Mentation Concerns.	Patients in the denominator who have had referral to, or provisions of supports as per organizational policies and resources.	Systems are encouraged to include a measure that that reflects a mentation care plan or review process unique to their system.

% of older adults screened for Mobility	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have been screened for mobility at start of care, recertification, resumption of care, and on change in condition as per the 4Ms care description and had that documented in the common record.	
% of older adults with a documented mobility goal or care plan added related to mobility improvement	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who have a mobility goal or mobility care plan documented in their chart.	Systems are encouraged to adapt this measure to match the specific care process that exist to act on mobility goal.

Outcome Measures

Below are a few suggested measures pulled from the currently requirements of the OASIS measure sets. Home health organizations are invited to choose alternate measures if they choose.

Table 10. Overview of Outcome Measures for the 4Ms in Home Health

Measure	Denominator	Numerator	Notes
Rehospitalization during the first 30 days of home health	Number of home health stays that begin during the 3-year observation period for patients who had an acute inpatient hospital discharge within the 5 days prior to the start of the HH stay.	Number of home health stays for patients who have a Medicare FFS claim for an admission to an acute care hospital in the 30 days following the start of the home health stay.	Home health organizations are able to use the claims based OASIS measure: **Rehospitalization During the First 30 Days of Home Health (Claims-based).** The same definition applies as found in the current outcomes measures guide. Measure should be stratified by age if possible to understand the variation by age brackets to support further improvement activities.
Rate of emergency department (ED) visits	Number of home health stays that begin during the 3-year observation period for patients who had an acute inpatient discharge within the 5 days prior to the start of the home health stay.	Number of home health stays for patients who have a Medicare FFS claim for outpatient emergency department use and no claims for acute care hospitalization in	Home health organizations are able to use the claims based OASIS measure: **Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (Claims-based).** The same definition applies as found in the current outcomes measures guide.

		the 30 days following the start of the home health stay.	Measure should be stratified by age if possible to understand the variation by age brackets to support further improvement activities.
Patient experience/What Matters Act On	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	Patients in the denominator who choose "top box" for the designated question as chosen by the organization.	Home health organizations are encouraged to choose a question(s) that represent patients perspective of if What Matter was acted on in their care. This can take the form of: • A measure or measures from an existing patient experience survey that asks about communication and listening from providers • A new measure that specifically asks "did we ask and address what mattered most to you during your care?" • The integration of questions from the validate collaborate tool as found here.
Change in mobility	All patients 65 years and older in the population considered to be patients of the entity/organization who have a home visit during the measurement period	See existing definitions in OASIS measures set	Home health organizations are encouraged to track improvements in the Total Normalized Composite (TNC) Change in Mobility measure as the 4Ms are being implemented in their care, using the definition already outlines in the OASIS measures set. Organizations might choose to focus on a different measure related to mobility to track the impact of the 4Ms if they feel it is better aligned to their focused improvement work.

Appendix G: Glossary of Terms

Assessment: For older adults who have a positive screen, or those at higher risk for a particular condition, a set of assessments and actions provides additional information about the person's condition that can further focus the care plan process and interventions. Assessment tools may include more detailed surveys, laboratory tests, radiology or imaging studies, quantitative and/or qualitative assessments by a skilled, trained clinician or team of clinicians. For example, a clinician's review of a Timed Up and Go may reveal issues with an older adult's gait and balance (e.g., weakness, unsteadiness while turning). Based on that initial screen, a more in-depth assessment by a physical therapist determines specific aspects of the older person's walking, turning, balance, strength, sensation, and cognition that will inform the design and implementation of the best care plan for that individual. Assessments may also be used to track changes in an older person's status over time.

Care partner or caregiver: A person (family or chosen family member, friend, neighbor, coworker, other) who supports an older adult with physical, psychological, financial, spiritual, or other issues related to health.

Health professional: A person who plays a role on the health care team or performs in a clinical role. Examples include physicians; nurses; social workers; pharmacists; mental or behavioral health providers (e.g., psychologists); physical, occupational, or speech therapists; recreational therapists; nutritionists; and others.

Interprofessional: Health care team member that works together with other health professionals to integrate each of their disciplines.

Marginalized: To marginalize a group means "to relegate to an unimportant or powerless position within society or group… examples of marginalized populations include groups that are excluded due to race, gender identity, sexual orientation, age, physical ability, or language."[3]

Multidisciplinary or interdisciplinary team: Health care teams comprising health professionals from multiple different disciplines such as nursing, medicine, therapy, and pharmacy.

Office: A term used to describe a section of a home health care organization. According to the Centers for Medicare & Medicaid Services (CMS), an office is a location from which an home health care organization provides services within a portion of the total geographic area served by the parent organization[4].

---

[3] Pratt A and Fowler T. "Deconstructing Bias: Marginalization." *The NICHD Connection*. Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health. 13(145):6. June 2022. https://science.nichd.nih.gov/confluence/pages/viewpage.action?pageId=242975243

[4] Electronic Code of Federal Regulations. 42 CFR Part 484 - Home Health Services. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484. Accessed January 1, 2025.

Primary care provider: A health professional that provides primary health care such as a physician, nurse practitioner, or physician's assistant.

Screening: A screening tool is a brief measure designed to identify individuals who may have signs or symptoms of a particular condition (such as dementia) or may be at greater risk of developing certain conditions. A positive result on a screening tool indicates that the person requires a more detailed evaluation by a trained clinician using an evidence-based or evidence-informed tool or set of assessment protocols. Screening tools may identify older adults early enough to provide treatment and avoid or reduce symptoms and other consequences.

Staging: Some (not all) conditions may have standardized staging criteria applied to individual cases to indicate which stage of an illness or condition they are in, and to track changes (improvement, decline) over time. Certain conditions (such as dementia) may have more than one staging method; therefore, it is important to know which methods are evidence-based and clinically appropriate. IHI does not require organizations to have specific staging tools or processes in order to be recognized as an Age-Friendly Health System. However, if staging is part of clinical care and care planning, we recommend that it be conducted by trained clinicians and documented in a place where all relevant team members may access the information.

References

[1] Neilsberg. 2024 update on the United States population by age. Available at: https://www.neilsberg.com/insights/united-states-population-by-age. Accessed January 8, 2025.

[2] Caplan Z and Rabe M. "The Older Population: 2020." US Census Bureau. 2020 Census Briefs, Report Number C2020BR-07. May 25, 2023. https://www.census.gov/library/publications/2023/decennial/c2020br-07.html

[3] Adapted from: Tinetti M. "How Focusing on What Matters Simplifies Complex Care for Older Adults." Institute for Healthcare Improvement Blog. January 23, 2019. https://www.ihi.org/insights/how-focusing-what-matters-simplifies-complex-care-older-adults

[4] *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*. Boston: Institute for Healthcare Improvement; 2020. https://241684.fs1.hubspotusercontent-na1.net/hubfs/241684/AgeFriendlyHealthSystems_GuidetoUsing4MsCare_FINAL_July2020.pdf

[5] U.S. Census Bureau. Revenues for Home Care, Elderly Services Increase. Available at: https://www.census.gov/library/stories/2022/08/revenues-for-home-care-elderly-services-increase.html. Accessed January 1, 2025.

[6] Ankota. Home Care Industry Overview and Statistics. Available at: https://www.ankota.com/home-care-industry-overview-and-statistics. Accessed January 1, 2025.

[7] Anderson TS, O'Malley AJ, Huskamp HA, Grabowski DC, McWilliams JM. Out Of Reach: Inequities In The Use Of High-Quality Home Health Agencies. Health Aff (Millwood). 2022;41(1):14-21. doi:10.1377/hlthaff.2021.01408.

[8] Anderson TS, O'Malley AJ, Huskamp HA, Grabowski DC, McWilliams JM. Out Of Reach: Inequities In The Use Of High-Quality Home Health Agencies. Health Aff (Millwood). 2022;41(1):14-21. doi:10.1377/hlthaff.2021.01408.

[9] Li Y, Harrington C, Temkin-Greener H, et al. Deficiencies in care at nursing homes and racial/ethnic disparities across homes fell, 2006–11. *Health Aff (Millwood)*. 2015;34(7):1139-1146.

[10] Fashaw S, Chisholm L, Mor V, et al. Inappropriate antipsychotic use: The impact of nursing home socioeconomic and racial composition. *J Am Geriatr Soc*. 2020;68(3):630-636.

[11] *Plan-Do-Study-Act (PDSA) Worksheet*. Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

[12] Guideway Care. Health Literacy and Hospital Readmission Rates. Available at: https://guidewaycare.com/health-literacy-and-hospital-readmission-rates. Accessed January 1, 2025.

[13] Southey C and Henriquez Garcia L. "Focusing on Equity at Every Step of Your Age-Friendly Health Systems Journey". Boston, MA: Institute for Healthcare Improvement; 2023. https://241684.fs1.hubspotusercontent-na1.net/hubfs/241684/Age-Friendly/Guides%20and%20Toolkits/Focusing%20on%20Equity%20at%20Every%20Step%20of%20Your%20Age-Friendly%20Health%20Systems%20Journey.pdf

[14] Nguyen M, Pachana NA, Beattie E, Fielding E, Ramis MA. Effectiveness of interventions to improve family-staff relationships in the care of people with dementia in residential aged care: A systematic review protocol. *JBI Database System Rev Implement Rep*. 2015;13(11):52-63.

[15] Scoville R, Little K, Rakover J, Luther K, Mate K. *Sustaining Improvement*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2016. http://www.ihi.org/resources/Pages/IHIWhitePapers/Sustaining-Improvement.aspx

[16] Podsiadlo D, Richardson S. The Timed "Up & Go": A test of basic functional mobility for frail elderly persons. *J Am Geriatr Soc.* 1991;39(2):142-148.

[16] Naik AD, Dindo L, Van Liew J, et al. Development of a clinically-feasible process for identifying patient health priorities. *J Am Geriatr Soc.* 2018 Oct;66(10):1872-1879.

[17] Tinetti ME, Esterson J, Ferris R, Posner P, Blaum CS. Patient priority-directed decision making and care for older adults with multiple chronic conditions. *Clin Geriatr Med*. 2016;32:261-275.

[18] *Condensed Conversation Guide for Identifying Patient Priorities (Specific Ask).* Patient Priorities Care. https://patientprioritiescare.org/resources/clinicians-and-health-systems/

[19] *Serious Illness Conversation Guide*. Ariadne Labs. https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources/#Downloads&%20Tools

[20] McCutcheon Adams K, Kabcenell A, Little K, Sokol-Hessner L. *"Conversation Ready": A Framework for Improving End-of-Life Care*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2015. *[See: Steward Principle]* https://www.ihi.org/resources/white-papers/conversation-ready-framework-improving-end-life-care

[21] *AGS 2023 Beers Criteria Pocketcard*. American Geriatrics Society; 2023. https://geriatricscareonline.org/ProductAbstract/2023-ags-beers-criteria-pocketcard/PC0015

[22] Hill-Taylor B, Sketris I, Hayden J, Byrne S, O'Sullivan D, Christie R. Application of the STOPP/START criteria: A systematic review of the prevalence of potentially inappropriate prescribing in older adults, and evidence of clinical, humanistic and economic impact. *J Clin Pharm Ther*. 2013;38(5):360-372.

[23] Maher RL, Hanlon JT, Hajjar ER. Clinical consequences of polypharmacy in elderly. *Expert Opin Drug Saf*. 2014;13(1).

[24] Borson S. Standardized Mini-Cog© Instrument. https://mini-cog.com/download-the-mini-cog-instrument/

[25] Welcome to the Patient Health Questionnaire (PHQ) Screeners. Pfizer. http://www.phqscreeners.com/

[26] Fick DM, Inouye SK, Guess J, Ngo LH, Jones RN, Saczynski JS, Marcantonio ER. Preliminary development of an ultrabrief two-item bedside test for delirium. *J Hosp Med*. 2015;10(10):645-650.

[27] Fick DM, Inouye SK, McDermott C, et al. Pilot study of a two-step delirium detection protocol administered by certified nursing assistants, physicians and registered nurses. *J Gerontol Nurs*. 2018;44(5):18-24.

[28] Stopping Elderly Accidents, Deaths & Injuries. *Assessment: Timed Up & Go (TUG)*. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2017. https://www.cdc.gov/steadi/media/pdfs/steadi-assessment-tug-508.pdf

[29] Shah N. The case against hospital beds. *Politico*. November 8, 2017. https://www.politico.com/agenda/story/2017/11/08/the-case-against-hospital-beds-000575

[30] Blaum C, Rosen J, Naik AD, et al. Initial implementation of patient priorities-aligned care for patients with multiple chronic conditions. *J Am Geriatr Soc*. 2018 Oct;66(10):2009-2016.

[31] Tinetti M, Dindo L, Daisy Smith C, et al. Challenges and strategies in patients' health priorities-aligned decision-making for older adults with multiple chronic conditions. *PLoS One*. 2019 Jun 10;14(6):e0218249.

[32] *Condensed Conversation Guide for Identifying Patient Priorities (Specific Ask).* Patient Priorities Care. https://patientprioritiescare.org/resources/clinicians-and-health-systems/

[33] Zomahoun HTV, Guénette L, Grégoire JP, et al. Effectiveness of motivational interviewing interventions on medication adherence in adults with chronic diseases: A systematic review and meta-analysis. *Int J Epidemiol*. 2017;46(2):589-602.

[34] Kiyoshi-Teo H, Northup-Snyder K, Cohen DJ, et al. Feasibility of motivational interviewing to engage older inpatients in fall prevention: A pilot randomized controlled trial. *J Gerontol Nurs*. 2019;45(9):19-29.

[35] American Society of Health-System Pharmacists. Beers Criteria Updates Handout. Available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/docs/Beers-Criteria-Updates-Handout.pdf. Accessed January 1, 2025.

[36] Lumish R, Goga JK, Brandt NJ. Optimizing pain management through opioid deprescribing. *J Gerontol Nurs*. 2018;44(1):9-14.

[37] Mattison ML, Afonso KA, Ngo LH, Mukamal KJ. Preventing potentially inappropriate medication use in hospitalized older patients with a computerized provider order entry warning system. *Arch Intern Med*. 2010;170(15):1331-1336.

[38] Reuben DB, Gazarian P, Alexander N. The Strategies to Reduce Injuries and Develop Confidence in Elders intervention: Falls risk factor assessment and management, patient engagement, and nurse co-management. *J Am Geriatr Soc*. 2017;65(12);2733-2739.

[39] Deprescribing Guidelines and Algorithms. Deprescribing.org. https://deprescribing.org/resources/deprescribing-guidelines-algorithms/

[40] O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Aging*. 2015;44(2):213-218.

[41] Alzheimer's Association. https://alz.org/

[42] Marcantonio ER. Delirium in hospitalized older adults. *N Engl J Med*. 2017;377:1456-1466.

[43] Larson EB. Evidence supports action to prevent injurious falls in older adults. *JAMA*. 2017;318(17):1659-1660.

[44] Wong CA, Jones ML, Waterman BM, Bollini ML, Dunagan WC. The cost of serious fall-related injuries at three Midwestern hospitals. *Jt Comm J Qual Patient Saf*. 2011;37(2):81-87.

[45] Klein K, Mulkey M, Bena JF, Albert NM. Clinical and psychological effects of early mobilization in patients treated in a neurologic ICU: A comparative study. *Crit Care Med*. 2015;43(4):865-873.

[46] AGS CoCare®: Hospital Elder Life Program (HELP) for Prevention of Delirium. AGS CoCare®: HELP program

[47] See, for example: Etchells E, Woodcock T. Value of small sample sizes in rapid-cycle quality improvement projects 2: Assessing fidelity of implementation for improvement interventions. *BMJ Qual Saf*. 2018;27(1):61-65.