Age-Friendly Care Beyond the Walls: Rethinking Traditional Models to Fully Deliver the 4Ms

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Objectives

- Evaluate why traditional physician-centric and setting-limited models (hospital, outpatient clinic, home health) are insufficient to deliver reliable Age-Friendly 4Ms Care, and identify system gaps that create missed opportunities in Medication, Mentation, Mobility, and What Matters.

- Analyze how expanded care models—particularly Outpatient in the Home and community-based OT/PT services—provide unique advantages for addressing the 4Ms comprehensively.

- Determine actionable strategies for interdisciplinary collaboration that empower all healthcare professionals not just physicians to share responsibility for 4Ms integration, improve transitions of care, reduce fragmentation, and enhance outcomes for older adults and caregivers.

Kara Welke, OTD, OTR/L, CLT, PWR, Skills2Care

Personal

- Occupational Therapist since 2000
- Grew up in SD, live in ND
- Hubby - Psychologist
- 3 Kids
  - OT, Nursing, Electrician
- Travel, Audio Books, Painting
- Love working with older adults!

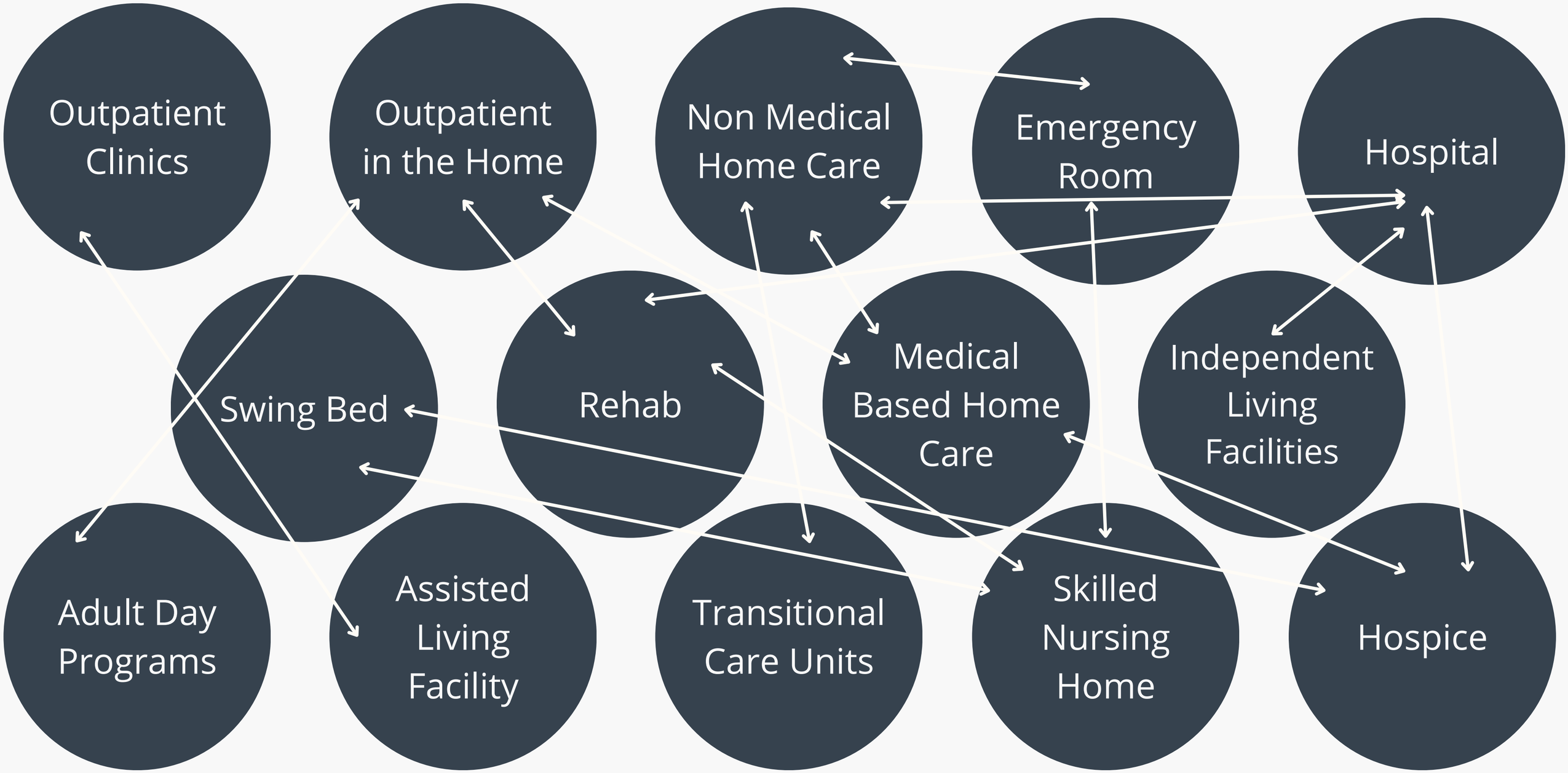
Next Level Occupational Therapy LLC

- Therapy Business Builder Program
- Home and Community Therapist Network
- Virtual and Live Events
- Therapist as Travel Professionals

Home Therapy Solutions LLC

- Mobile Therapy Services
- Focus on Geriatrics & Women's and Men’s Health
- Clinic location within an ILF
- Contracts with HHA, SNF, Senior Center Memory Care Facility, 55+ Community
- CNA Services
- Specialty Areas
  - Home and Community Based Care
  - Home Safety Assessments
  - Dementia
    - Skills2Care Program
      - Clients with Dementia & their Caregivers
    - Cognitive Stimulation Therapy
  - Parkinson’s Disease - PWR
  - Lymphedema - CLT

Healthcare System: Complex & Overwhelming



1 in 5 patients experience suboptimal or unsafe care around hospital discharge due to loss of continuity and coordination challenges between multiple providers/agencies.

Tyler et al., 2023

Primary Themes in Care Transitions

(Based on patient & caregiver experiences)

Uncertainty about the new care setting

- Not knowing what life will be like in the next place (home, rehab, assisted living).

Disruption to daily life and routines

- Changes in independence, roles, and “normal life” that feel unsettling.

Importance of continuity of care

- Patients want the same providers and clear, consistent information to avoid repeating their story or getting conflicting advice.

Need for emotional and practical support

- Families need reassurance, guidance, and resources to manage stress and new responsibilities.

Earl, Katapodis, & Schneiderman, 2020

The U.S. Healthcare System Is Over Capacity

- The demand for care already exceeds the system’s capacity—resulting in fragmentation, inequity, and burnout.
- By 2030, the U.S. is projected to face shortages of ~1.2 million registered nurses and ~121,900 physicians.
- Rural, low-income, and underserved communities will face the greatest access barriers.
- Fragmentation drives duplication, medical errors, higher spending, and poor outcomes.
- Burnout and turnover threaten continuity, quality, and trust in care.

Jones & Dolsten 2024, citing AAMC 2023 & HRSA Nursing Workforce Data 2022–2023

Research shows older adults receive ≈50% of recommended care:

- Current quality measures miss what matters most for aging adults
- Social, psychological, and functional needs are rarely assessed
- Fragmentation + lack of person-centered metrics → poor outcome

MacLeod et al., 2022

Older Adults Receive Only Half of the Care They Need

Research shows older adults receive ≈50% of recommended care
Current quality measures miss what matters most for aging adults
Social, psychological, and functional needs are rarely assessed
Fragmentation + lack of person-centered metrics → poor outcomes

MacLeod et al., 2022

Cognitive impairment is massively underdiagnosed
Only 8% of expected MCI cases are detected in primary care. → **Over 90% go unrecognized.**[1]

Up to 1 in 5 people with Mild Cognitive Impairment (MCI) may revert to normal cognition — but they remain at higher risk of later decline.[2]

Increased Risk for Dementia: The Surgeon General's advisory indicates that **loneliness and social isolation are linked to a nearly 50% increased risk of developing dementia**, emphasizing the need to address social factors in prevention strategies.

[1] Liu et al., 2023
[2] Anand & Schoo, 2024

The Front Line of Dementia Care Is Underprepared

Primary care physicians report:

- 39% **uncomfortable diagnosing** dementia
- 27% uncomfortable **answering dementia questions**
- 22% **received no dementia training**
- **65% of those trained received very little**
- ***Yet 82% say they are the front line of dementia care.***

Alzheimer's Association (2020)

Older adults are deeply dissatisfied with care

- 82% of older adults say the U.S. health care system is not prepared for the growing and changing needs of aging adults.
- Only 11% give the health care system an “A” grade.
- Older adults want care that:
  - Maximizes function, independence, and quality of life
  - Is affordable
  - Addresses cognitive decline, mental health, and mobility
  - Is aligned with what matters most to them.

The John A. Hartford Foundation, 2024

Quality of life > living longer

94% say it is more important to maintain quality of life than simply to live as long as possible.

- Yet:
  - 58% say providers ask about what matters most to them.
  - 40% report routine cognitive assessments.
  - 45% report mental health being evaluated.
  - 55% say providers evaluate mobility/physical fitness.

The John A. Hartford Foundation, 2024

- 52% of Medicare beneficiaries see 3+ physicians per year.
- Half of older adults say their primary care provider does not coordinate with other providers.
- 56% find the system difficult and stressful to navigate.
- 62% say insurance plans offer too many confusing choices.
- 55% mistakenly believe Medicare covers long-term nursing home stays.

The John A. Hartford Foundation, 2024

The Caregiver Crisis

63 million American adults provided ongoing care in 2025.

- 1 in 4 adults in the U.S.
- The number of caregivers grew 45% since 2015

National Alliance for Caregiving & AARP, 2025

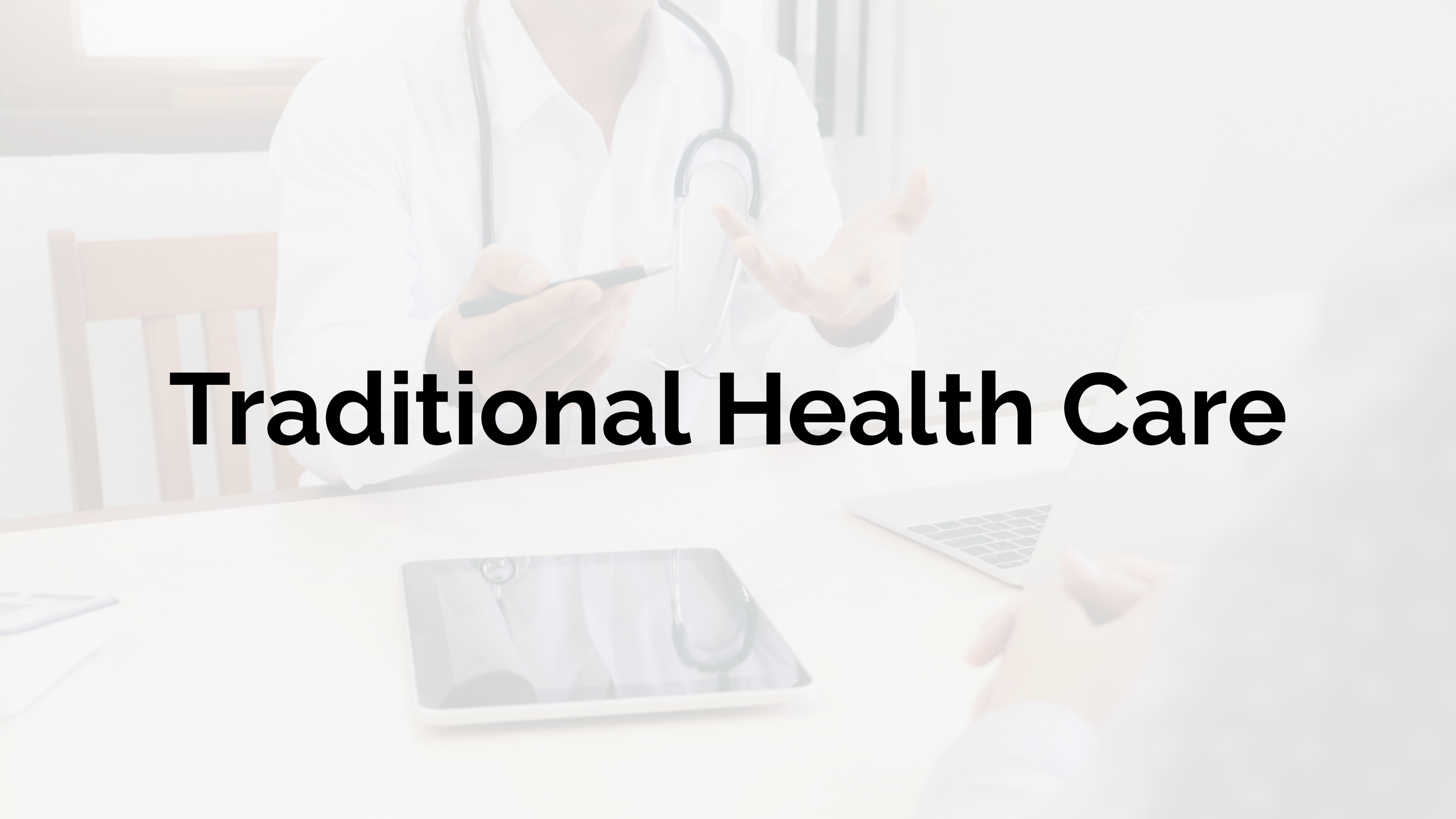
Research to support Ways to Reduce Caregiver Hours

- Home modifications reduced the need for care by 6.32 hours per week.
- This study confirms the positive human impact effects of modifying housing, in particular bathrooms, and demonstrates that home modifications directly reduce the need for care in the home by up to 46%.

Carnemolla & Bridge, 2019

- Out of 119 patients after hospitalization, 79 (66%) needed new medications.
- 87.4% received instructions for new meds.
- Only 66.7% got guidance on combining with existing meds.[1]
- Between 40–75% of older adults in the community don’t follow their medication routines.[2]
- Non-adherence can cause adverse events, side effects, hospitalization, or institutionalization.[2]
- An estimated 60% of medication errors occur during transitions due to poor communication[3]

[1] Leithaus et al., 2025.
[2] Somerville et al., 2019
[3] Satake & McElroy, 2024



Traditional Health Care

Home Health

According to CMS data, the average number of visits per 30-day Home Health episode in 2023 was:

- Skilled Nursing: 3.86 visits
- Physical Therapy: 2.78 visits
- Occupational Therapy: 0.76 visits
- Speech-Language Pathology: 0.14 visits
- Medical Social Services: 0.05 visits
- Home Health Aide: 0.42 visits

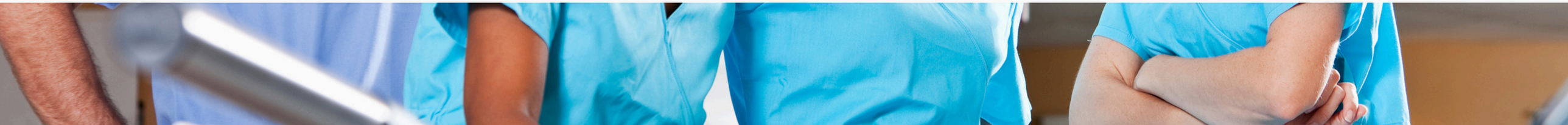
Healthcare Financial Management Association, 2024

Therapists often report being pressured to keep sessions under one hour and complete documentation during the visit—conditions that compromise both treatment depth and therapeutic outcomes.

Even before PDGM was fully enacted, therapy thresholds were eliminated in 2019, triggering a steady decline in therapy utilization. By 2024, CMS (2023) reported that a larger proportion of Home Health episodes included only one to five therapy visits, and overall therapy use had decreased across all clinical groupings compared to pre-PDGM years (2018–2019).

Not only are the number of visits limited, but CMS data (2025) also reveals that the duration of these visits is often well under an hour.

For non-first visits in non-LUPA episodes, the average duration is 41.54 minutes for skilled nursing (SN), 45.11 minutes for physical therapy (PT), 47.15 minutes for speech-language pathology (SLP), and 45.98 minutes for occupational therapy (OT).



Average Home Health Episode 2023: **PT 2.78 visits | OT 0.76 | SLP 0.14.**
Average duration ≈ 45 min—**insufficient for holistic 4 M care.**

PRIMARY CARE PROVIDER VISITS

Primary care consultation time is insufficient for many older adults and high-need populations.

- Most primary care visits last around 10–15 minutes,
- Older adults and patients with multiple conditions routinely require 20–30+ minutes, and
- Mental health visits often exceed 30–60 minutes.”

Short, fixed appointment times lead to:

- Missed diagnoses
- Limited patient-centered communication
- Reduced shared decision-making
- Inequitable care for vulnerable groups
- More inappropriate prescribing
- Lower quality of chronic disease management[1]

[1] Fryer et al., 2023

HOSPITALIZATION

Study: Nguyen et al., 2021 (JAGS)
Population: 1,031 hospitalizations in adults ≥65 hospitalized ≥14 days
Setting: Safety-net hospital

Average Amount of Rehab Older Adults Receive
Median rehabilitation duration (RD): 61.3 minutes per week
(Interquartile Range: 16.5–127.3 min/week)
This equals:
~8.7 minutes/day of combined PT + OT
Despite being hospitalized for 14+ days, where they are at highest risk of functional decline.

- Older adults hospitalized ≥14 days are at high risk of
- functional decline, mobility loss, and new disability.

Nguyen et al., 2021 (JAGS)

REHABILITATION

20
22

OUTPATIENT IN THE HOME

Outpatient therapy provided in the home has long been an established and reimbursable service, as outlined by the Centers for Medicare & Medicaid Services (CMS). According to CMS (2025, Chapter 15, Sec. 220.1.4, pg. 156), therapy services are payable under the Physician Fee Schedule when furnished by:

- A provider to its outpatients in the patient's home
- A provider to patients seen at the facility's outpatient department
- A provider to inpatients of other institutions
- A supplier to patients in the office or in the patient's home

(Note: Comprehensive Outpatient Rehabilitation Facility (CORF) regulations differ when it comes to therapy provided in the home.)

Outpatient therapy services delivered in the home are reimbursed at the same rate as services provided in outpatient clinics. However, travel expenses incurred by providers for visiting a patient's home are not reimbursed

(CMS, 2025, Chapter 15, Sec. 220.1.4, pg. 157).

Conditions for Coverage

To qualify for outpatient therapy services in the home, three conditions must be met:

- The individual requires (or required) therapy services.
- A plan of care has been established by a physician, non-physician practitioner (NPP), or the treating therapist, and is periodically reviewed by a physician or NPP (42 CFR 424.24(c), §220.1.2).
- The services are furnished while the individual is under the care of a physician (42 CFR 424.24(c), §220.1.1).

Skilled therapy may be required to:

- Improve a patient's current condition
- Maintain functional abilities
- Prevent or slow further decline

(CMS, 2025, Chapter 15, Sec. 220.2, pg. 158)

Industry Shifts and Practice Trends

Since the implementation of PDPM (Patient-Driven Payment Model) and PDGM (Patient-Driven Groupings Model), outpatient therapy delivered in the home has seen significant growth. These payment model changes led to widespread layoffs in institutional settings, prompting many therapists to seek alternative practice models. In response, our Therapy Business Builder program launched in October 2019 to support therapists in starting their own mobile outpatient practices—many of whom have since found success in this model.

Key Considerations and Limitations

- It is essential to understand that outpatient therapy in the home is not covered when a patient is receiving services under Home Health Medicare Part A. These two services cannot be billed simultaneously.
- In an ideal scenario, a patient who is homebound and qualifies for Home Health under Medicare Part A should receive therapy and other services through this benefit, which does not require copays and offers a team-based approach—including nursing, therapy, home health aides, and more.
- However, in practice, many Home Health agencies limit therapy services, dictating the number of visits based on business policy rather than clinical need. In some cases, clients are kept on Home Health services even after they are no longer homebound, which restricts access to outpatient therapy services they may benefit from.

Key Considerations and Limitations

- Ideally, Home Health should serve as a transitional support system—bridging hospital or skilled nursing facility discharge with the goal of regaining independence. Once the patient no longer meets homebound criteria, they should be transitioned to outpatient therapy, which can be provided either in the home or in a clinic, depending on what best serves the client.

- These numbers simply do not align with the level of care individuals on Home Health should receive. For example, research on home safety assessments and modifications alone supports the need for two to three initial occupational therapy sessions, followed by a six-month booster session for optimal effectiveness and long-term outcomes.

(Norin et al., 2021; Fishpool & Bridge, 2012; McBride, Story, & Cason, 2023; S. Stark, personal communication, December 2024).

With the right services in place, clients are better supported to maintain function, prevent rehospitalizations, and continue living safely and independently at home.

Unfortunately, we continue to encounter challenges in educating hospital and rehabilitation discharge planners.

These professionals frequently limit their recommendations to Medicare Part A Home Health agencies listed on Care Compare, which are assigned Star Ratings. Because mobile outpatient therapy practices under Medicare Part B are not included in these directories or given Star Ratings, our services are often excluded from discharge planning conversations—even though we have consistently educated providers on the key differences between Home Health (Part A) and Mobile Outpatient Therapy (Part B).

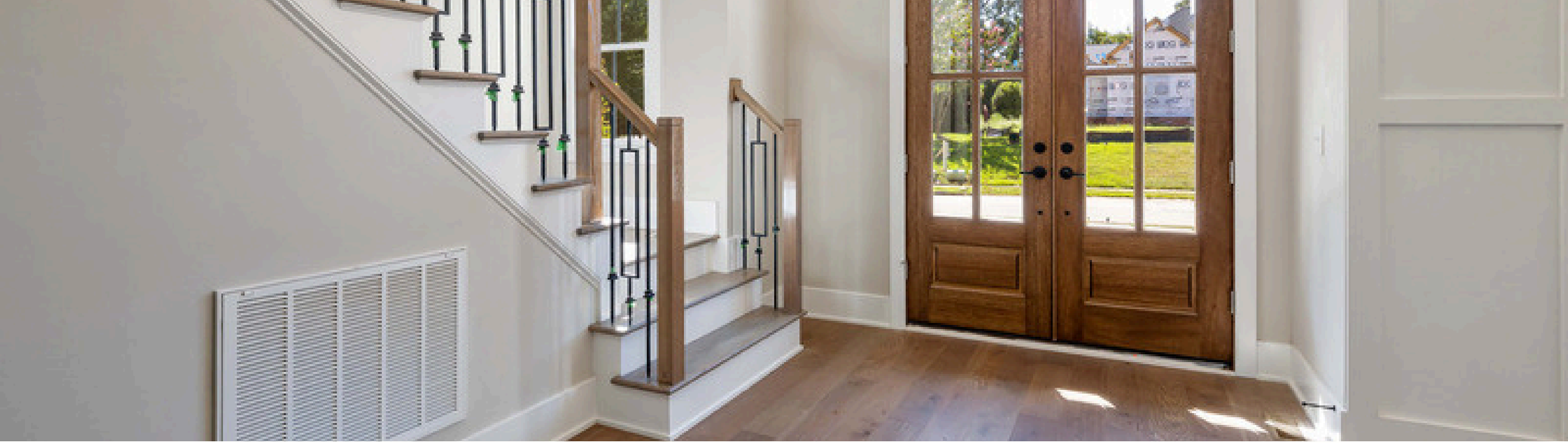
For example, if you visit the Care Compare website and and search for Home Health providers, you will not find outpatient therapy practices that deliver care in the home under Part B.

Mobile outpatient model (Part B) offers 2–3 visits/week with goal-based progression.

Maintennece

What Matters

Being in the person’s own home and community allows us to understand their true priorities, routines, values, and goals. This is where “what matters” becomes visible and meaningful.



Mobility

HCBS lets us assess and improve mobility in the spaces where it matters most—hallways, bedrooms, bathrooms, steps, uneven surfaces, community environments, and familiar routines. We must expand beyond the home in order to ensure aging in the RIGHT place.

Mentation

Cognitive and emotional functioning often present differently in unfamiliar settings. In the home, we can observe real cognitive demands, triggers, supports, social connections, and daily patterns that affect mentation.

Medications

Home visits reveal the real-world medication situation: expired meds, duplicate bottles, unfilled prescriptions, pillbox challenges, risky storage locations, and adherence issues that no clinic can see.

Multi-Complexity: Home is where we can fully understand and manage the interplay of medical, functional, cognitive, social, environmental, and caregiver factors. HCBS allows us to see:

- Food insecurity
- Home safety concerns
- Social isolation
- Caregiver stress
- Transportation barriers
- Financial strain
- Poor access to services
- Multiple chronic conditions interacting together
- These complexities are often invisible in clinic settings—but always visible in the home.

Keys to Success in Transitions

- **Community Partnerships:** Integrated, efficient care.
- **Interprofessional Collaboration:** Unified approach ensures aligned, coordinated care.
- **Environmental & Social Factors:** Housing, transportation, psychosocial needs impact outcomes.
- **Patient/Caregiver Engagement:** Improves understanding, safety, and satisfaction.
- **Quality Improvement & Leadership:** Executive level support, training, assessment.

(Scott AM et al., 2017)

Putting it all together:
Essentials for Successful Care Transitions

Community Partnerships

- Providers + community resources working together reduce gaps and duplication.
- Supports coordinated care across settings.

Interprofessional Collaboration

- Clear communication and shared responsibility across teams ensures continuity.
- Ensures consistent patient/caregiver education and coordinated care.

Patient-Centered Care

- Address social, environmental, and daily life needs, not just medical tasks.
- Includes safe medication management and support for daily routines.

Information & Scheduling

- Timely, accurate follow-up appointments and transport checks reduce missed care.
- Directly supports timely follow-up across settings.

(Earl et al., 2020; Scott et al., 2017)

Putting it all together:
Essentials for Successful Care Transitions

Patient & Caregiver Involvement

- Active partners in planning, education, and red-flag awareness build confidence.
- Highlights patient/caregiver education with teach-back and medication safety.

Organizational Support

- Leadership, resources, and engaged staff sustain effective transitions.
- Provides structure for consistent risk screening and readiness assessments.

Continuous Evaluation

- Ongoing feedback, monitoring, and adaptation improve outcomes over time.
- Reinforces risk screening and tracking outcomes to refine care.

(Earl et al., 2020; Scott et al., 2017)

Case Study

Case Study

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