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Purpose:

Hospital at Home (HaH) programs deliver acute hospital-level care in the home, with evidence showing reduced infections, greater satisfaction, and cost savings.

Older adults face complex needs including:

- Mobility
- Cognition
- Medications
- individualized care

The Age-Friendly Health Systems 4Ms Framework (What Matters, Medication, Mentation, Mobility) provides a structured approach to optimize older adult care.

Methods:

This quality improvement initiative applies to the 4Ms within an HaH program through interdisciplinary collaboration.

•Mobility (PT):

- Tinetti, 10-Meter Walk
- Fall risk screening
- Progressive Personalized goals

•Mentation (RN):

- CAM-ICU, Delirium Checklist
- Cognitive engagement via movement
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•Medication (Pharmacist):

- Beers Criteria
- Structured admission tools

•What Matters (APPs, Physicians):

- Goal-aligned care
- Patient priorities



Discussion:

Improved Function & Safety

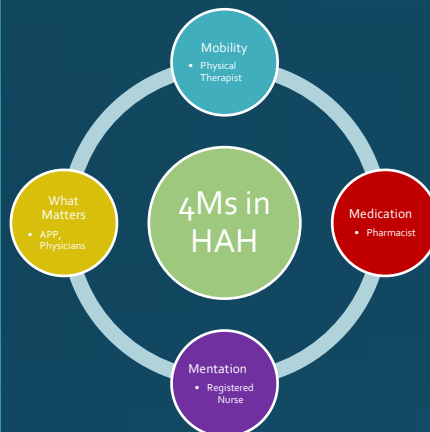
- Personalized PT-led mobility plans enhance functional outcomes.
- Tailored home safety assessments reduce environmental risks and fall rates.
- Home-Based Advantage
- Familiar environments support context-specific functional tasks.
- Patients engage more naturally in daily routines.

• Embedding the 4Ms aligns with:

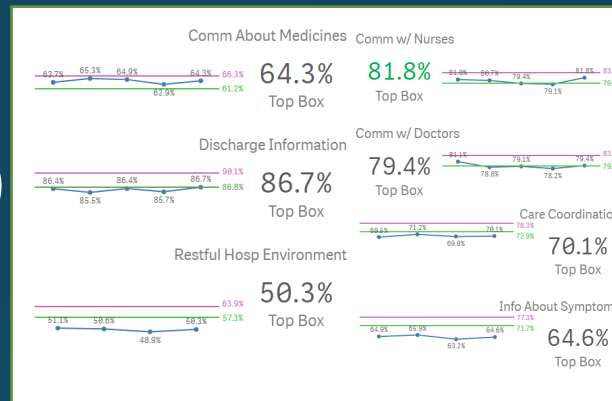
- Value-based care
- Geriatric best practices
- Enhanced safety, satisfaction, and outcomes

Gait speeds

>1 m/s	•1.1 m/s predictive of completing yard work •1.3 m/s climb flights of stairs
< 1 m/s	• benefit from fall prevention •0.47 m/s to complete self care •0.89 m/s for household activities
< .60 m/s	• predicts future risk of falls and hospitalization • tend to require assistance with ADL and IAD • ≤ 0.49 m/s to cross street
<0.40 m/s	• longer length of stay in acute care • likely to discharge to skilled nursing, inpatient rehab, or nursing home setting or with home health services



FY2025 Patient Experience



~ 2300

Patients Treated

9000

Bed Days

6 %

30 Day
Readmission
Rate

90th %ile

Patient Experience
Scores

99th %ile

Team Member
Engagement

Meeting Patients Where they are....



Understanding a home



Medication Education



Patient Instructions



Arranging Follow-up



Link to Social Resources

6 %

30-Day
Readmission Rate



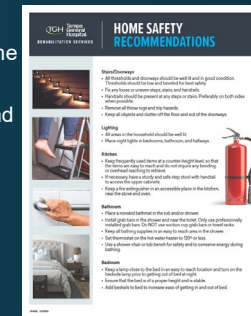
14 %

30-Day
Readmission Rate



Summary of use:

- Provides a scalable blueprint for integrating the 4Ms into Hospital at Home (HaH) programs.
- Highlights PTs' leadership in Mobility and interdisciplinary collaboration across all domains.
- Supports gradual, QI-driven adoption through:
- Technology infrastructure
- Enables safe, goal-oriented care for complex aging-in-place patients.



Importance to Members:

- Embedding the 4Ms ensures high-quality, person-centered care for older adults in HaH settings.
- PT and nursing collaboration improves functional and cognitive outcomes.
- Reduces readmissions, enhances safety, and boosts patient satisfaction.
- Aligns with system goals:
- Better outcomes
- Shorter length of stay
- More individualized, dignified care for aging population

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TGH At Home
Website

