# A Unique Model to Improve Care Transitions: FlourishCare Centers of Excellence

Barbara Gordon, M.A.
Pam Yankeelov, Ph.D.
Jessica Elkin, B.A.

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# Disclosures

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Session Roadmap

# What We'll Cover Today

After attending this session, participants will be able:

- To identify key successes, challenges, and best practices in the implementation of FlourishCare Centers of Excellence (FC-CEs).
- To evaluate effective partnership models and workforce development strategies that can be replicated in other regions to improve healthcare coordination for older adults.



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# A Case Example

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# The Case: Mr. Alvarez, Age 74

## PATIENT PROFILE

- Age 74 — admitted after a fall at home that caused a vertebral compression fracture
- **History:** type 2 diabetes and mild cognitive impairment
- Lives alone since his wife's passing
- **Goal:** return home, resume cooking, and keep driving to church

## HOSPITAL ASSESSMENT & PLANNING

- **Cognition:** mild impairment at baseline, no acute confusion; pain managed with non-sedating medicines
- Pharmacist adjusted diabetes medicines and held a blood pressure medicine causing dizziness on standing
- Physical therapy began the day after surgery — walking with a walker by discharge
- A clear care plan was documented in the hospital

# Transition 1: Hospital → Nursing Home

## WHAT THE SUMMARY LEFT OUT

- The summary listed his medicines and how well he could walk — but three things were missing
  - His usual (baseline) thinking pattern
  - Why his blood pressure medicine had been held
  - His goal of returning home

## THE CONSEQUENCES

- Evening confusion mistaken for new-onset dementia rather than his stable baseline
- Blood pressure medicine restarted unknowingly — he fell two days later
- Therapy focused only on moving within the facility, never toward his home goals like cooking

# Transition 2: Nursing Home → Home

## WHAT WAS DROPPED AGAIN

- The nursing home summary noted the fall and the medicine change, but dropped critical details
  - Never explained the blood pressure medicine had been restarted in error
  - Never told family about his memory and thinking changes
  - No record of his therapy progress came home with him

## THE CONSEQUENCES AT HOME

- Family unprepared for evening confusion — alarm led to an unnecessary ER visit
- Home health didn't flag the BP medicine — dizziness on standing returned
- No one asked about driving; he had quietly stopped weeks earlier, fearing lost independence
- Home physical therapy had to restart its assessment from scratch

# The Missing Link: Where Care Broke Down

1. The hospital, nursing home, and home health teams each managed only their own piece of his care.

2. The hospital's care plan never transferred into the nursing home discharge summary.

3. No one connected him to the aging network that could have carried his baseline, goals, and safety needs across every handoff.

An engaged Area Agency on Aging — with a shared record and a consistent point of contact — could have carried Mr. Alvarez's baseline, goals, and safety needs across every transition, preventing each avoidable harm.

# A Unique Model to Improve Care Transitions

**F**lourish**C**are **E**nhanced (FC-E):

A grant-funded initiative training healthcare and supportive care networks to improve patient outcomes for older adults.

**F**lourish**C**are **C**enter of **E**xcellence (FC-CE):

A regional hub transforming care for older adults across Kentucky.

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# Flourish Care Centers of Excellence

### PURPOSE:

Unite professionals from universities, healthcare providers, community organizations, and local governments to improve how care is provided to older adults.

### GOAL

Equip healthcare professionals with specialized knowledge needed to support aging adults across all care settings and ensure smooth transitions of care.

### COMMUNITY PARTNERSHIPS

Work closely with local partners to give older adults easily access to personalized services that support independence, dignity, and well-being.

### COORDINATED NETWORK

Connect hospitals, nursing homes, senior care programs, and government services into one seamless, coordinated system of care.

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# Geriatrics Workforce Enhancement Program (GWEP)

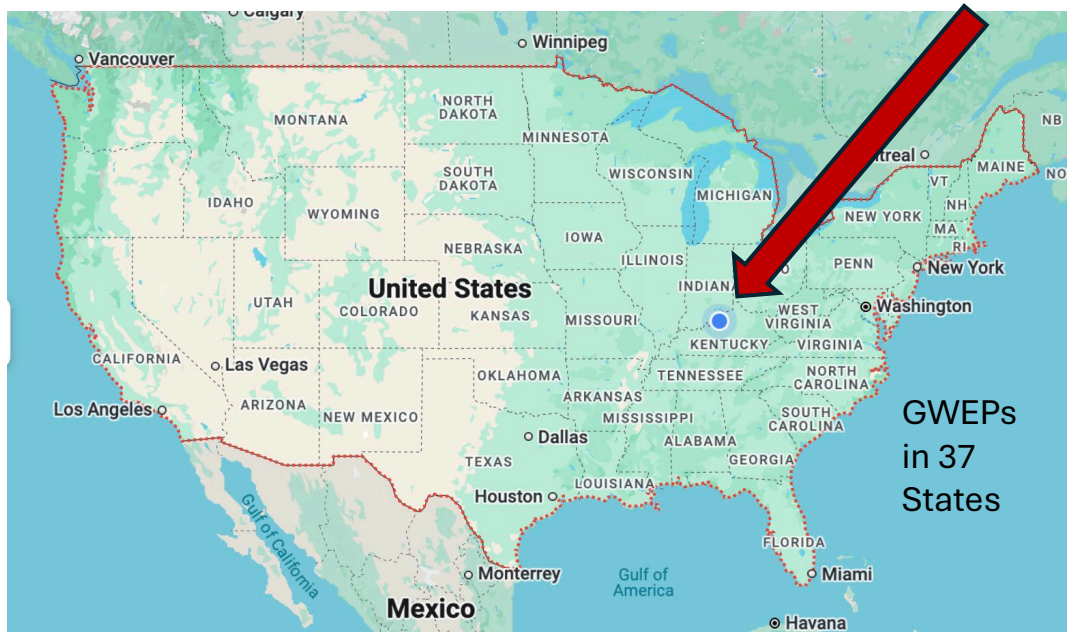
**PURPOSE:**

Improve health outcomes for older adults by developing a healthcare workforce that maximizes patient and family engagement, and by integrating geriatrics and primary care.

**GOALS:**

1) ***Educate and train*** the primary care and *geriatrics workforce* to care for older adults in integrated geriatrics and primary care models, and

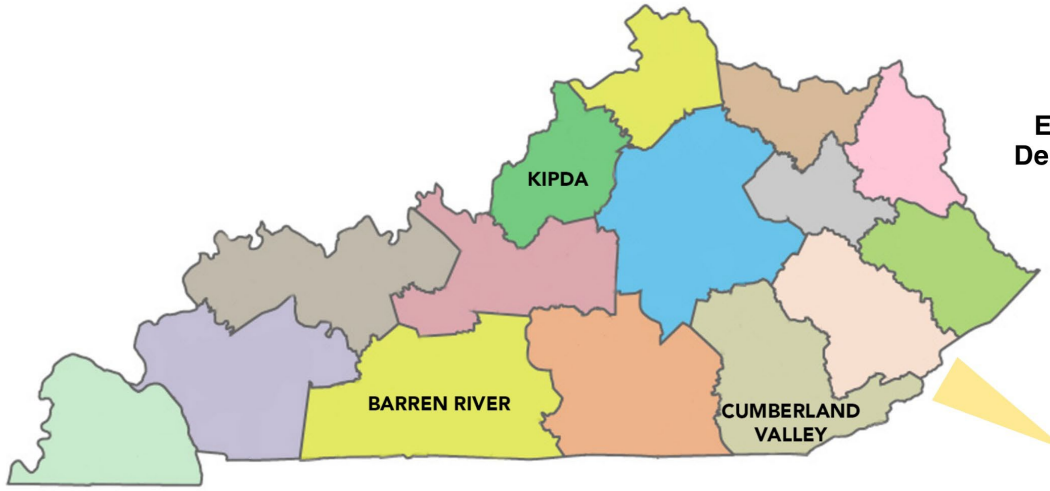
2) ***Transform clinical training environments*** into integrated geriatrics and PC systems to become *age-friendly health systems*



# FlourishCare

## CENTERS OF EXCELLENCE

PERSON-CENTERED AND AGE- AND DEMENTIA-FRIENDLY HEALTHCARE AND TRANSITIONS OF CARE







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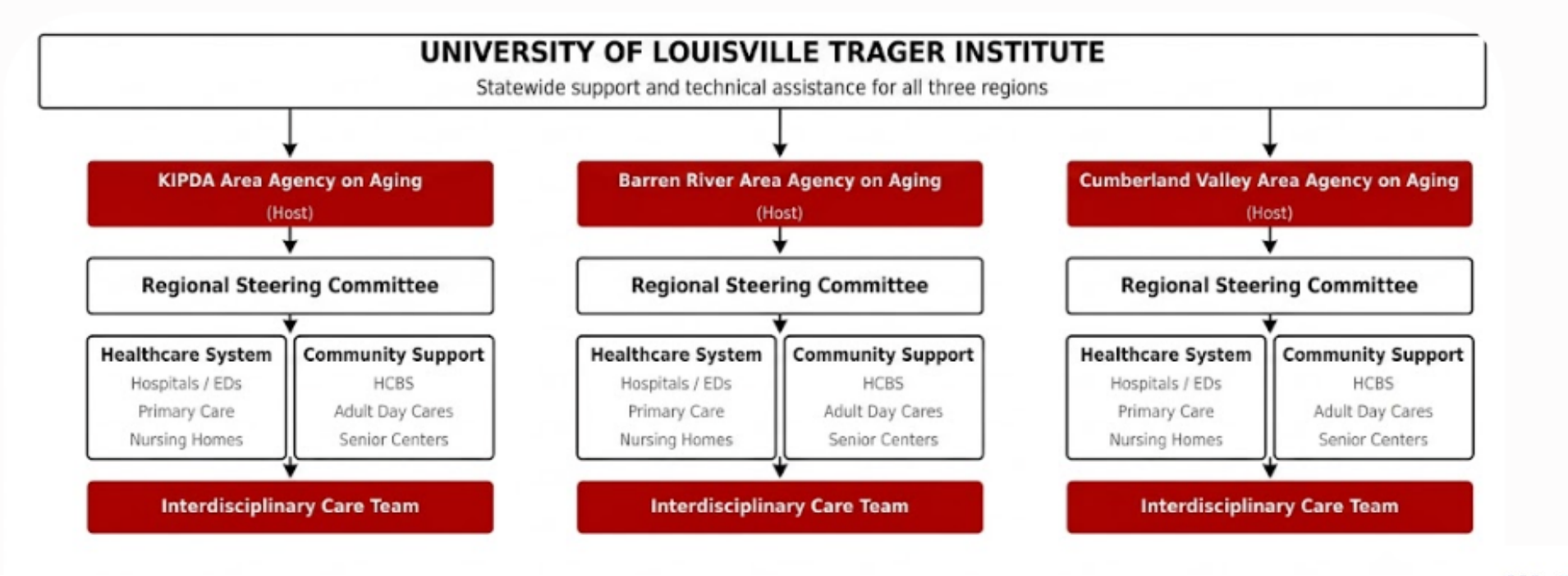
# FlourishCare Centers of Excellence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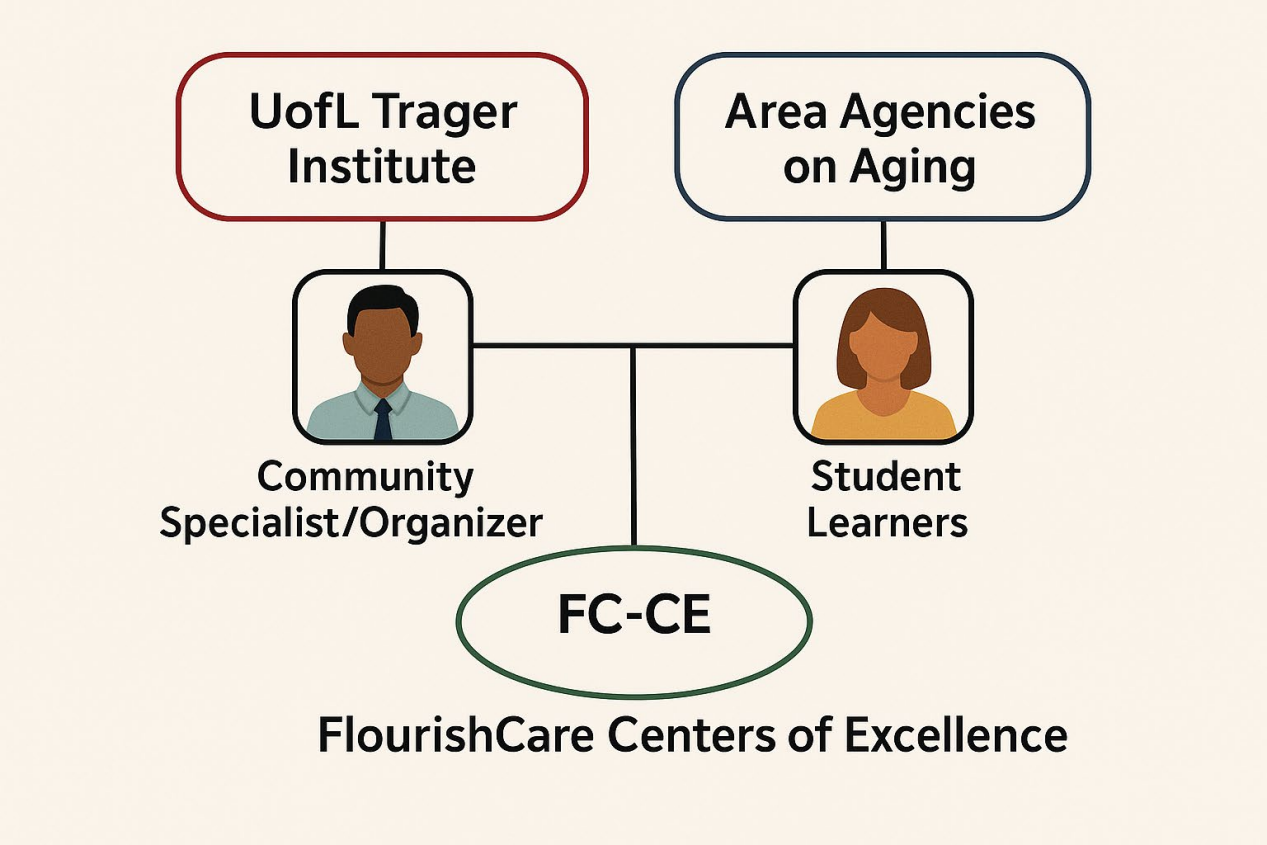
# FlourishCare Centers of Excellence (FC-CE)

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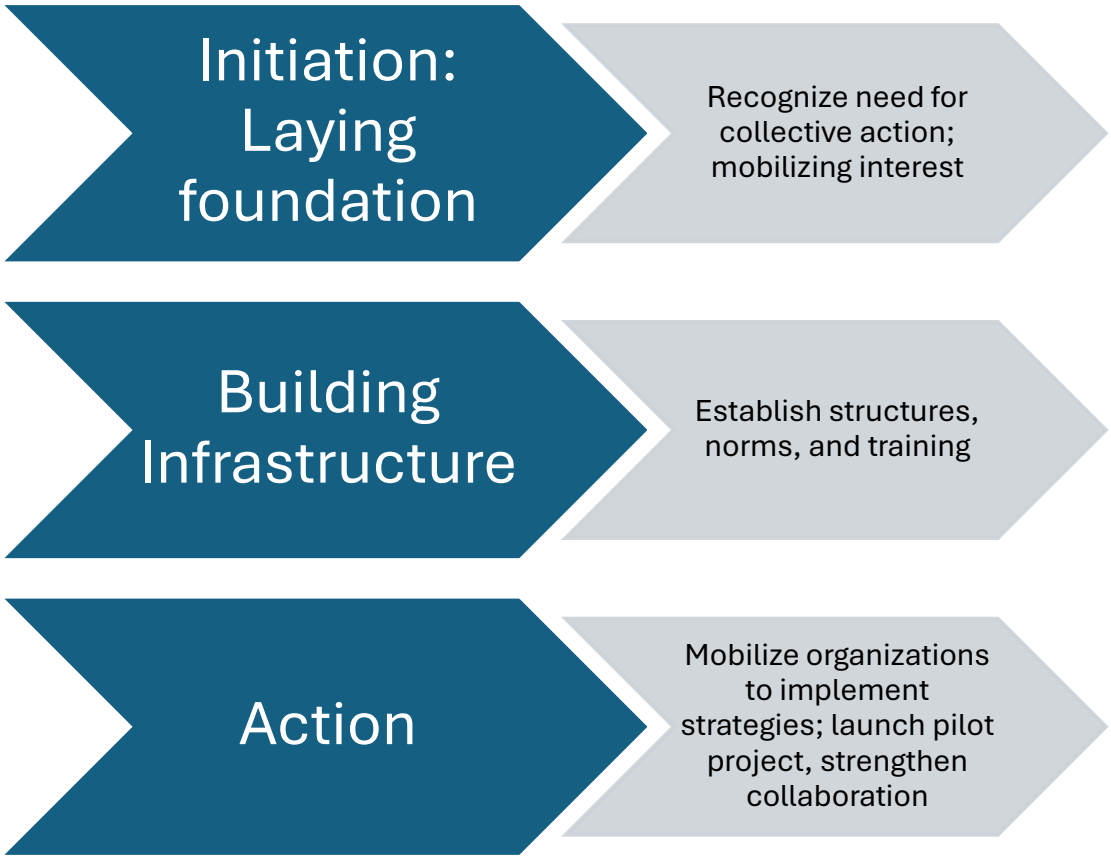
# FC-CE Driven by Community Capacity Development

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# Initiation: Laying Foundation

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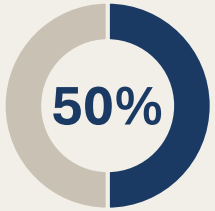
# Initiation: Laying Foundation

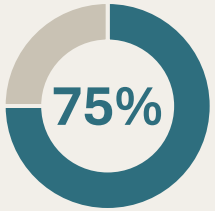
## STAKEHOLDER ENGAGEMENT

- Individual meetings with potential steering committee members
- In-person meetings held
- **Workforce Development Survey** conducted on Age-Friendly Health System (AFHS)
- **Practice Transformation Needs** — top barriers to care transitions:
  - Transportation
  - Access to resources & in-home services
  - Care coordination & caregiver support

## WORKFORCE DEVELOPMENT SURVEY




reported confidence in Age-Friendly Health System (AFHS)




reported never having implemented or facilitated Age-Friendly Health System (AFHS) training

# Building Infrastructure (Structure): Vision & Mission

## Vision Statement

- The FlourishCare Center of Excellence Steering Committee envisions a Kentucky where every older adult receives compassionate, coordinated, and evidence-based care that supports dignity, independence, and quality of life.

## Mission Statement

- The mission of the FlourishCare Center of Excellence Steering Committee is **to transform healthcare for older adults across Kentucky** through collaboration, education, and innovation. The Committee unites **academic, healthcare, community, and state partners** to promote **age- and dementia-friendly, person-centered care** and to **strengthen the workforce** that supports smooth, equitable transitions of care.

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# Building Infrastructure (Norms): Committee Goals

**Goal 1:**

Committee constituents will develop a **comprehensive understanding of Age Friendly Health Systems** that will enable them to facilitate the implementation of Age Friendly Health Systems training in their organizations.

**Goal 2:**

Committee constituents will identify 2 **barriers to transitions of care for older adults** and **create an action plan** to address and remove barriers.

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# Building Infrastructure

FlourishCare Centers of Excellence

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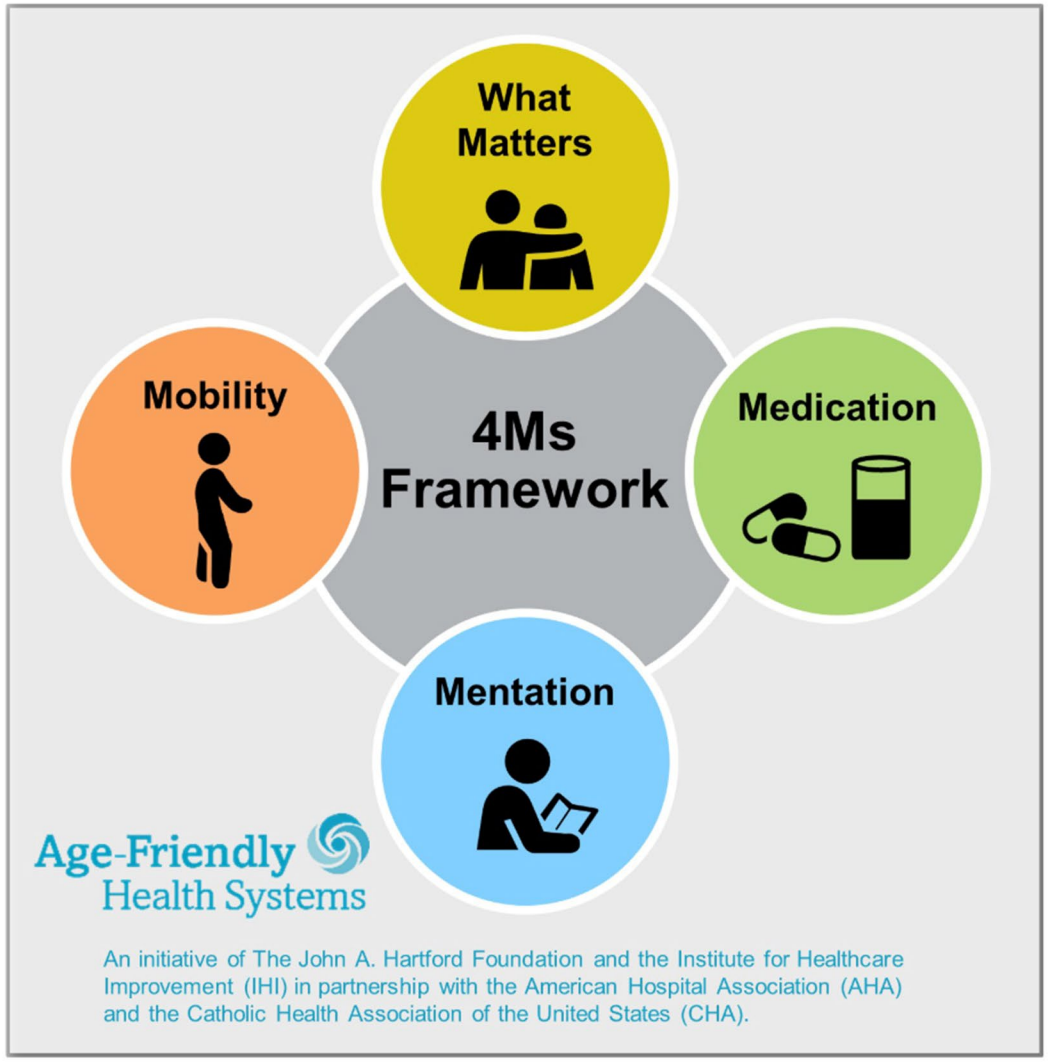
# Building Infrastructure (Training) : Workforce Development




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

**What Matters**

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

**Medication**

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

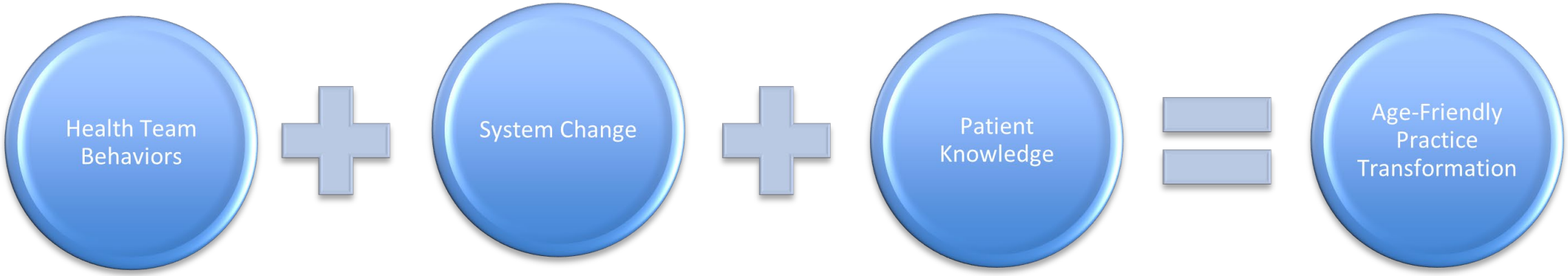
**Mentation**

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

**Mobility**

Ensure that older adults move safely every day in order to maintain function and do What Matters.

# Building Infrastructure (Workforce Development): 4Ms Training




4Ms Framework creates a shared language
**within** and **across** settings

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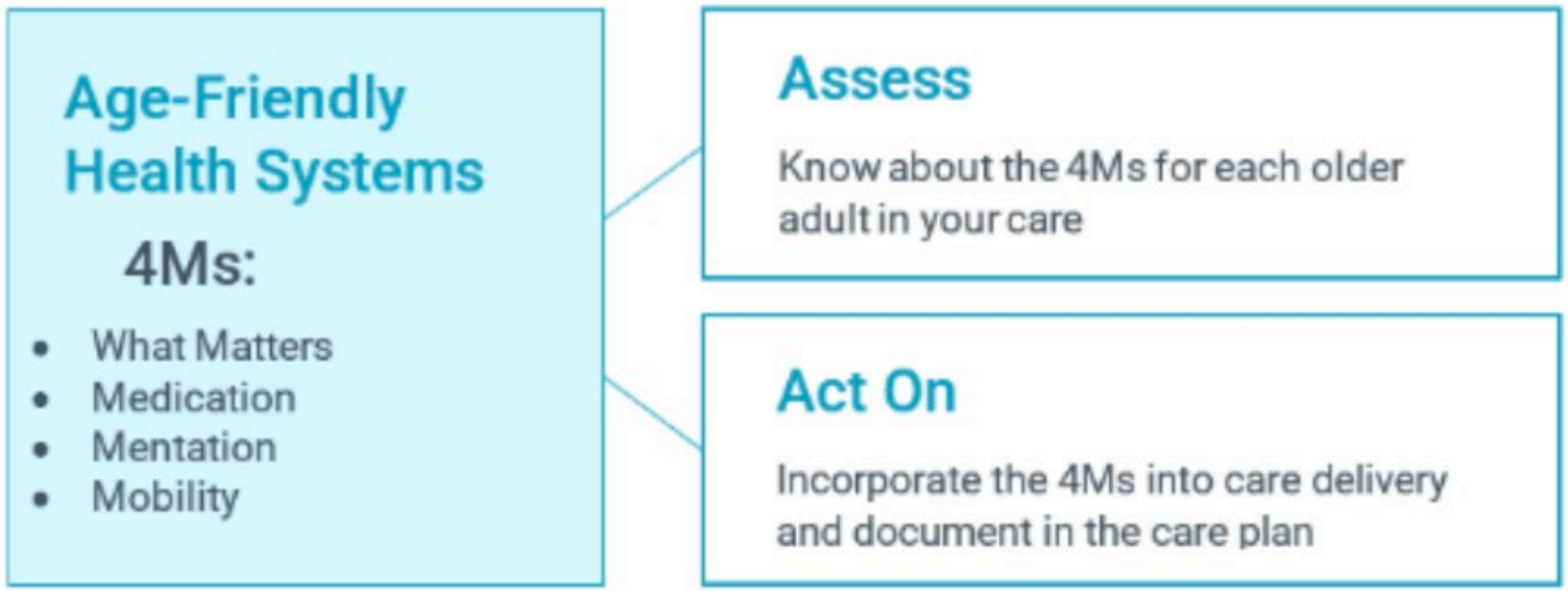
# Building Infrastructure: 4Ms Training

Ideal care expectations established
for **Health Care Teams**

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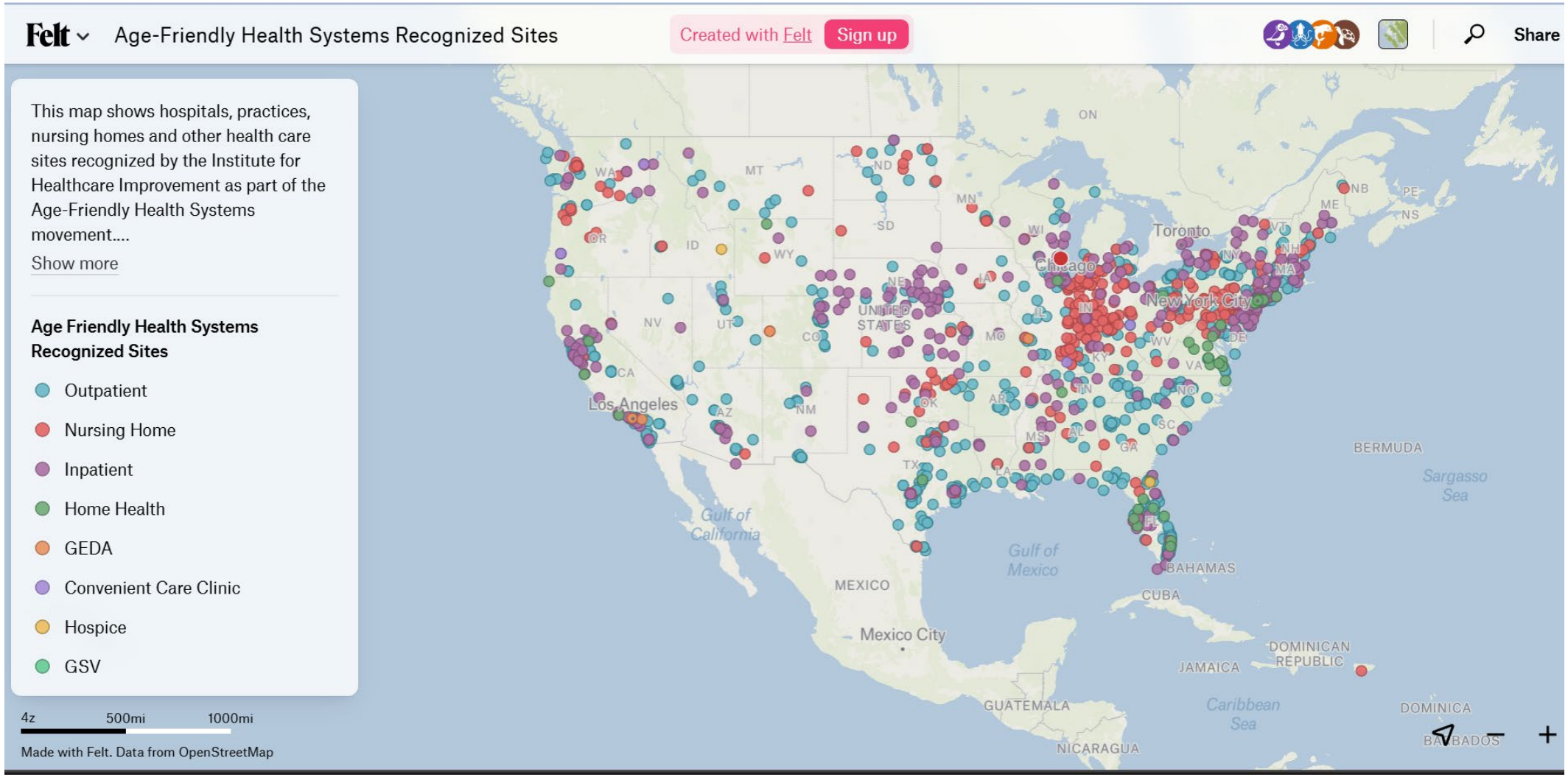
# Building Infrastructure: 4Ms Training

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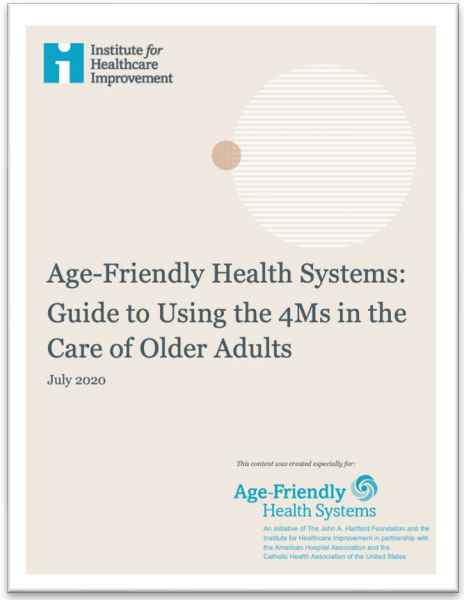
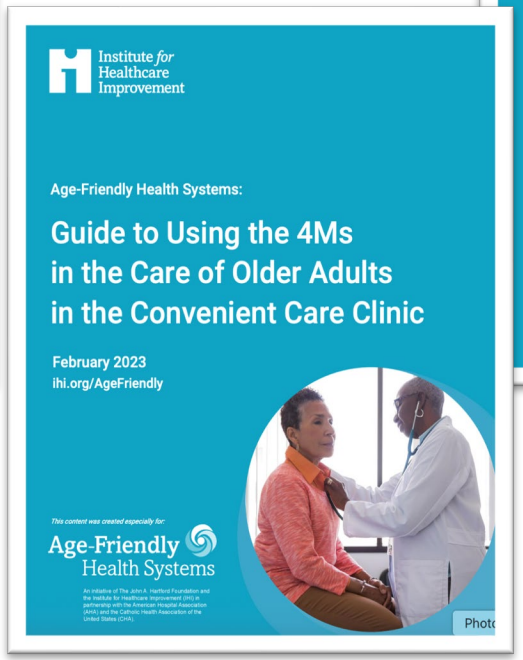
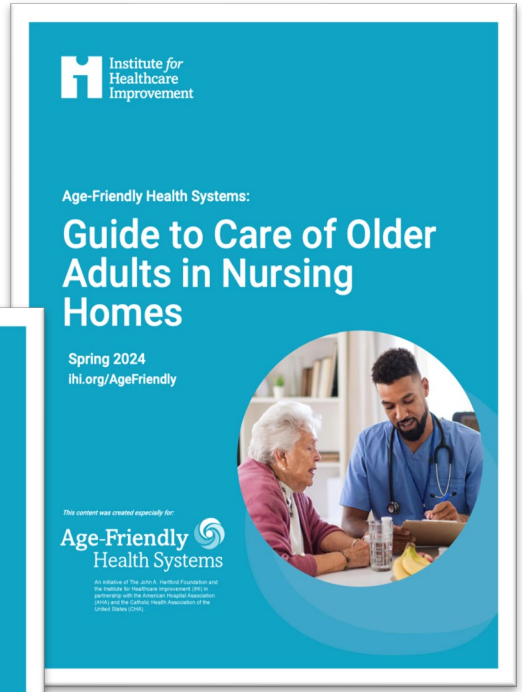
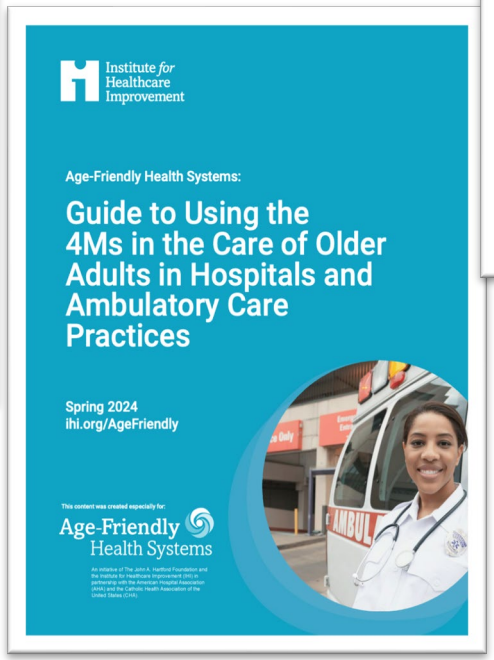
# Building Infrastructure: 4Ms Training

https://www.ihi.org/age-friendly-health-systems-resources-and-news





PLUS:

Level 1 and Level 2 Age-Friendly Health Care Recognition

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# And..

## CMS Age-Friendly Measure: Overview for Hospitals and Health Systems

Institute for Healthcare Improvement

Starting with the 2025 reporting period, hospitals will attest to providing age-friendly care through a new measure introduced by the Centers for Medicare & Medicaid Services (CMS).

The CMS Age Friendly Hospital Measure advances the Age-Friendly Health Systems movement's vision to ensure that all older adults receive age-friendly care that is evidence-based and aligns with what matters most to the older adult and their family caregivers. To date, nearly 5,000 sites of care have been recognized as Age-Friendly Health Systems — Participants and celebrated by IHI and The John A. Hartford Foundation. The measure has five domains that cover all four elements of age-friendly care, known as the 4Ms: What Matters, Medication, Mentation, and Mobility.

### Why the Measure Matters

- **Bolstering leadership buy-in**: The measure lets health system champions take both a top-down and bottom-up approach within their organizations while providing reliable, equitable, evidence-based care.
- **Advance preparation:** This attestation-based, self-reported measure has a low barrier. We anticipate additional benefits and/or consequence for age-friendly care delivery in the future. Starting the work now to achieve recognition as an Age-Friendly Health System allows for time to get ahead.
- **Acknowledgement and celebration:** Most health systems deliver at least some of the 4Ms for some older adults in their care. The measure brings a new opportunity to celebrate nationally the work that health systems are already doing. The five domains of the measure complement the 4Ms of age-friendly care, illustrated in the table:

**CMS Age Friendly Measure domains (from the Federal Register) and the 4Ms**

| Domain | Crosswalk to 4Ms |
|---|---|
| **Eliciting patient healthcare goals**: This domain focuses on obtaining patients' health-related goals and treatment preferences, which will inform shared decision-making and goal-concordant care. | What Matters |
| **Responsible medication management**: This domain aims to optimize medication management by monitoring the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm | Medication |

iPhone

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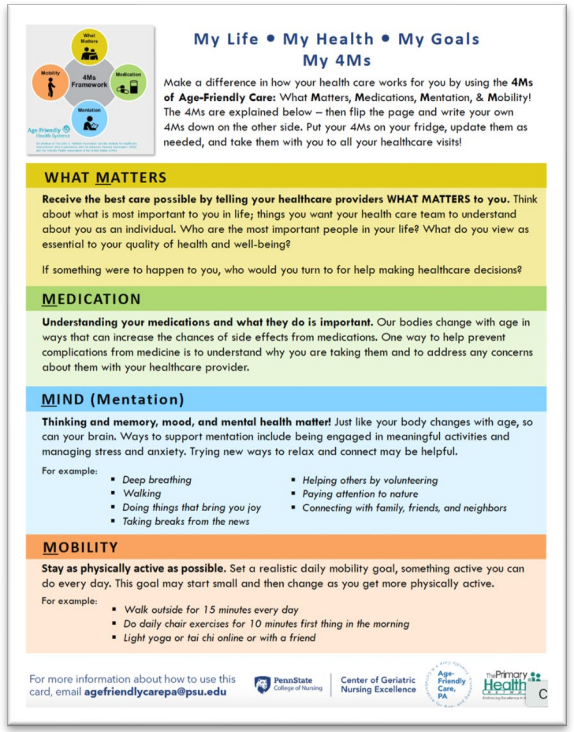
# Building Infrastructure: 4Ms Training

## ESTABLISHING **PATIENT/CLIENT EXPECTATIONs**



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# Building Infrastructure: Additional Training Opportunities


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# Building Infrastructure: Communication Strategies

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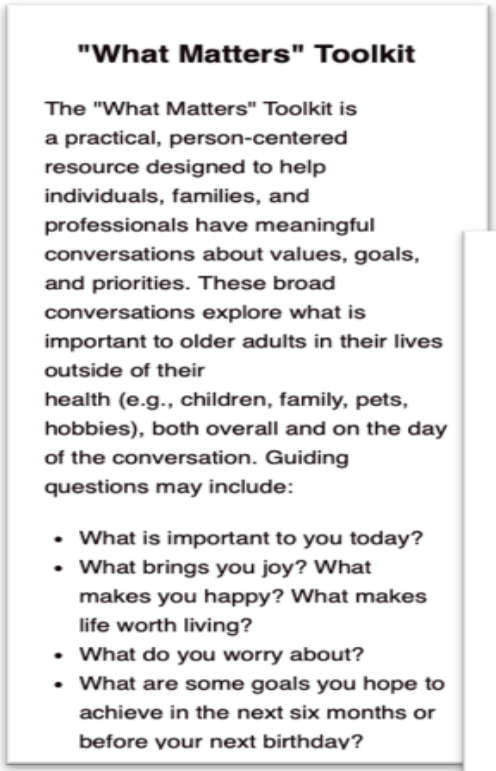
**FLOURISHCARE CENTERS OF EXCELLENCE NEWSLETTER SEPTEMBER 2025**

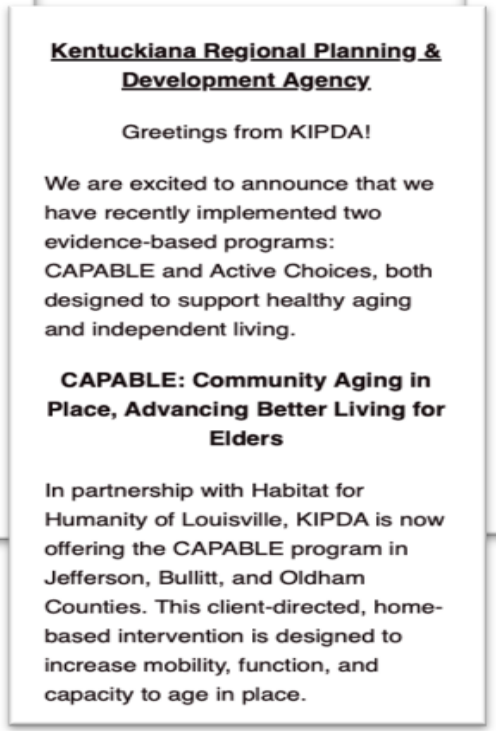
FlourishCare Centers of Excellence (FC-CE) brings together experts from universities, healthcare providers, community organizations, and local governments to improve how care is provided to older adults. Their goal is to make sure healthcare professionals have the specialized knowledge needed to support aging adults in all areas of care.



**"What Matters" Toolkit**

The "What Matters" Toolkit is a practical, person-centered resource designed to help individuals, families, and professionals have meaningful conversations about values, goals, and priorities. These broad conversations explore what is important to older adults in their lives outside of their health (e.g., children, family, pets, hobbies), both overall and on the day of the conversation. Guiding questions may include:

- What is important to you today?
- What brings you joy? What makes you happy? What makes life worth living?
- What do you worry about?
- What are some goals you hope to achieve in the next six months or before your next birthday?



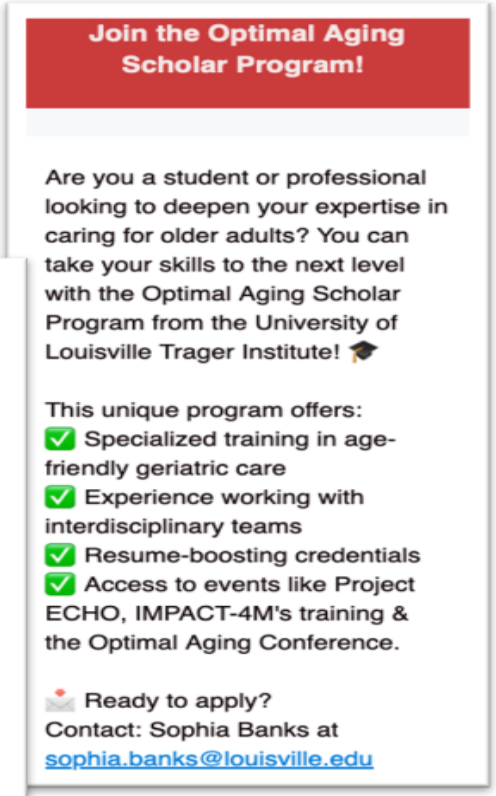
**Kentuckiana Regional Planning & Development Agency**

Greetings from KIPDA!

We are excited to announce that we have recently implemented two evidence-based programs: CAPABLE and Active Choices, both designed to support healthy aging and independent living.

**CAPABLE: Community Aging in Place, Advancing Better Living for Elders**

In partnership with Habitat for Humanity of Louisville, KIPDA is now offering the CAPABLE program in Jefferson, Bullitt, and Oldham Counties. This client-directed, home-based intervention is designed to increase mobility, function, and capacity to age in place.



**Join the Optimal Aging Scholar Program!**

Are you a student or professional looking to deepen your expertise in caring for older adults? You can take your skills to the next level with the Optimal Aging Scholar Program from the University of Louisville Trager Institute! 🎓

This unique program offers:
✅ Specialized training in age-friendly geriatric care
✅ Experience working with interdisciplinary teams
✅ Resume-boosting credentials
✅ Access to events like Project ECHO, IMPACT-4M's training & the Optimal Aging Conference.

📩 Ready to apply?
Contact: Sophia Banks at sophia.banks@louisville.edu

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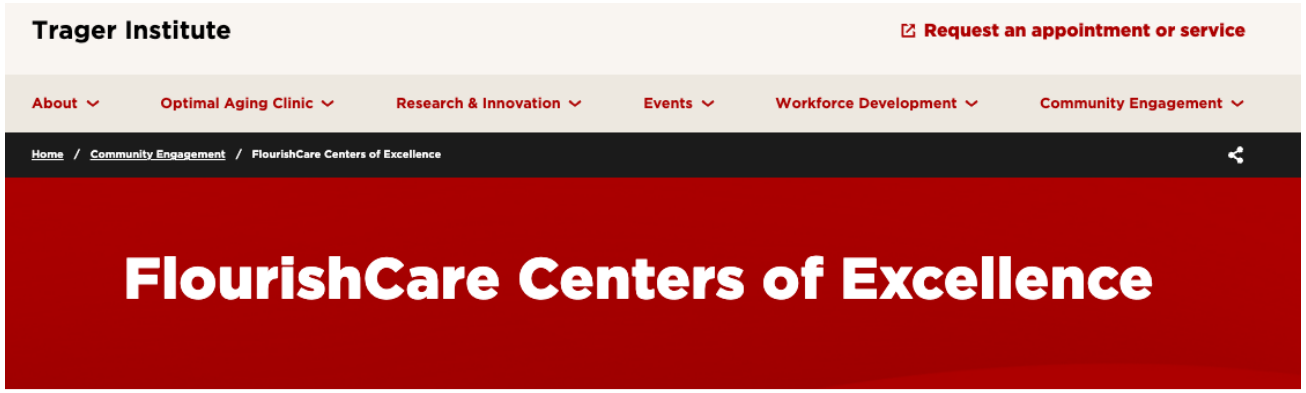
# Building Infrastructure: Webpage




## Creating age-friendly health systems throughout Kentucky

The FlourishCare Centers of Excellence (FC-CE) bring together academic education and training systems, health care systems, community support networks and state organizations and associations to transform care delivery by integrating specialized geriatric knowledge and skills within primary care.

### How they work

Area Agencies on Aging (AAAs) located in the FC-CE service areas are the community network leads, acting as central coordinators for community networks in the FC-CE regions to ensure all systems collaborate effectively to provide comprehensive patient-centered and team-based care. The AAAs are supported by a steering committee dedicated to age- and dementia-friendly initiatives, including representatives from all partner entities and older adult advocates.

There are currently three Centers of Excellence serving the counties located in the Kentuckiana Regional Planning and Development Agency (KIPDA), Barren River Area Development District (BRADD) and Cumberland Valley Area Development District (CVADD) regions.

### Steering committees

The steering committees work in collaboration with their local AAA and community partners to identify and eliminate barriers to transitions of care for older adults.

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# Action

FlourishCare Centers of Excellence

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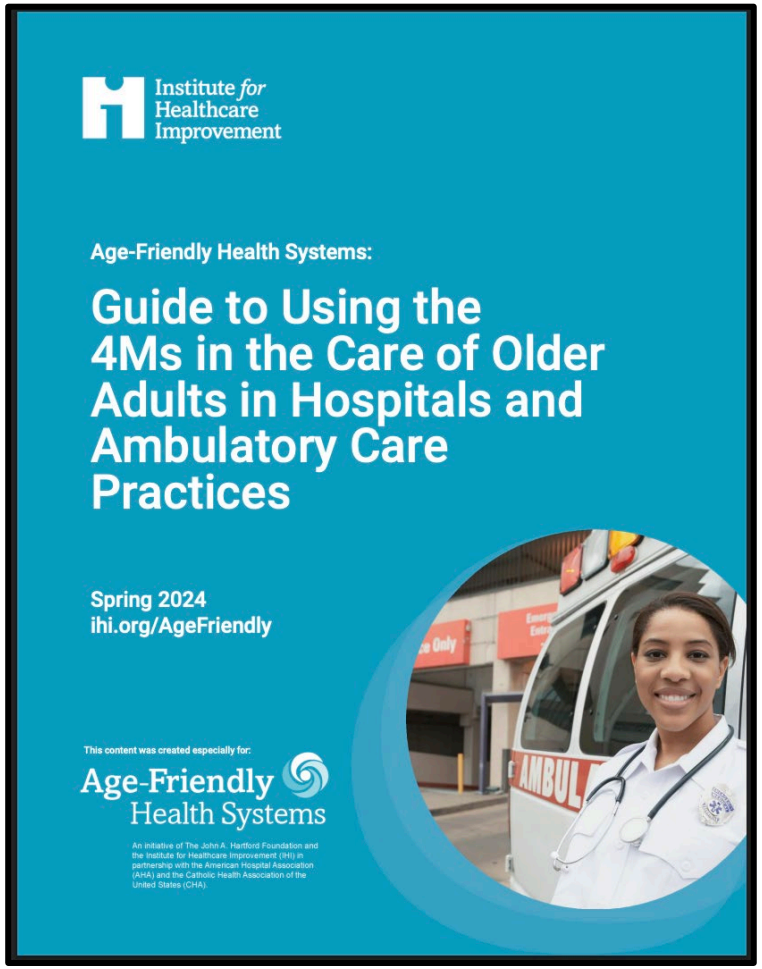
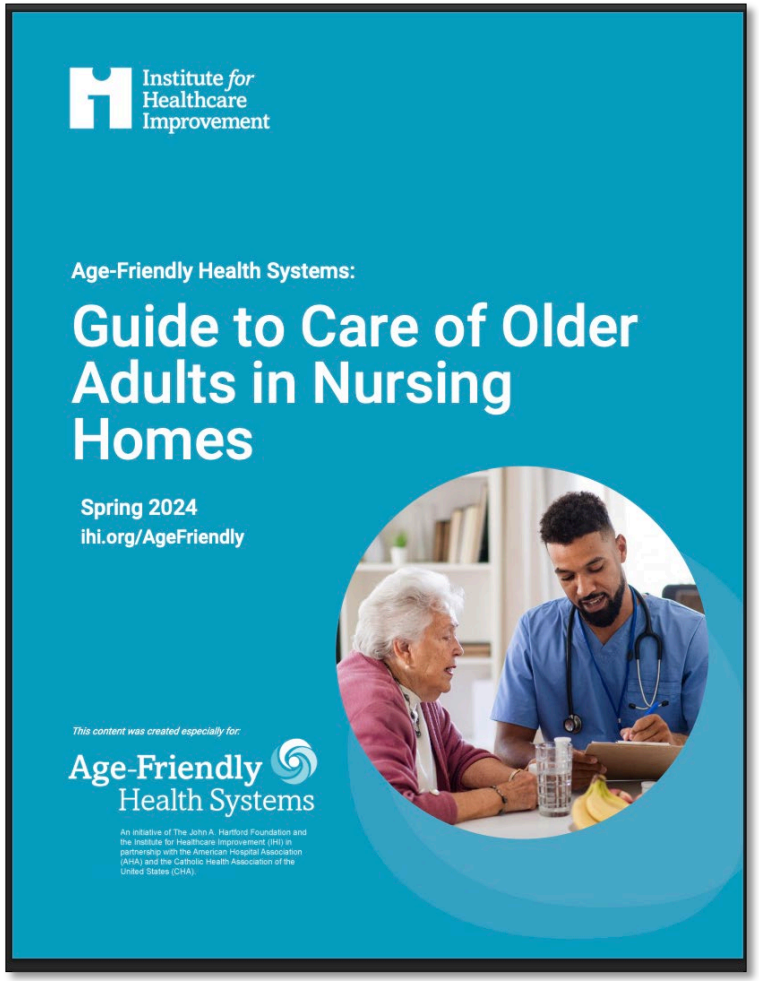
# Action: Age Friendly Health System Recognition

3 Nursing homes
4 Primary Care

Received
AFHS Recognition
Level 1 : Participant
Designation!

2 hospitals
demonstrated
interest.



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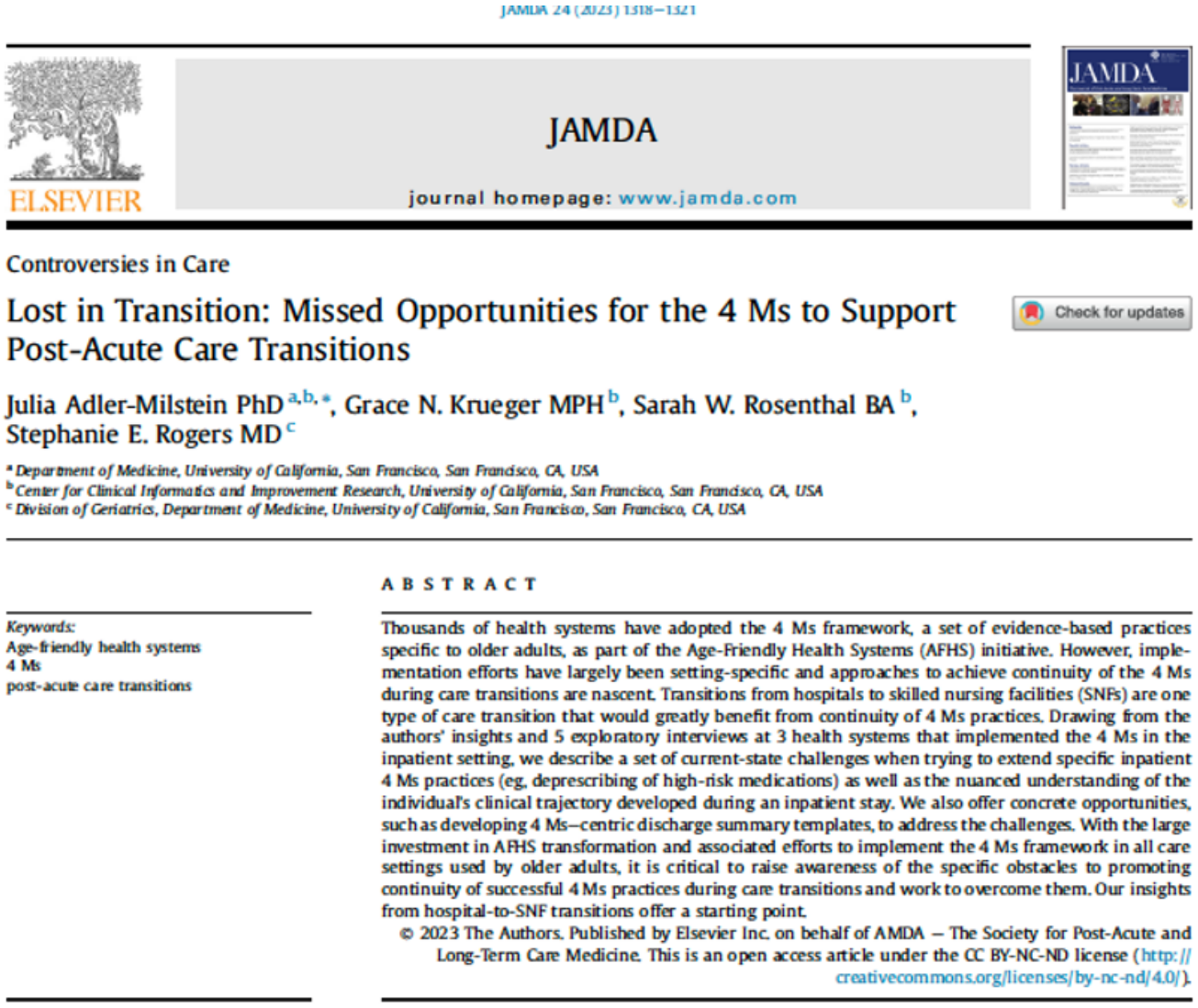
# Action: Programming

# Action: Literature Example for Engagement Purposes

Adler-Milstein, J., Krueger, G. N., Rosenthal, S. W., & Rogers, S. E. (2023). Lost in Transition: Missed Opportunities for the 4Ms to Support Post-Acute Care Transitions. JAMDA, 24(7), 1318–1321. https://doi.org/10.1016/j.jamda.2023.06.001



JAMDA 24 (2023) 1318–1321

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journal homepage: www.jamda.com

Controversies in Care

## Lost in Transition: Missed Opportunities for the 4 Ms to Support Post-Acute Care Transitions

Julia Adler-Milstein PhD [a,b,*], Grace N. Krueger MPH [b], Sarah W. Rosenthal BA [b], Stephanie E. Rogers MD [c]

[a] Department of Medicine, University of California, San Francisco, San Francisco, CA, USA
[b] Center for Clinical Informatics and Improvement Research, University of California, San Francisco, San Francisco, CA, USA
[c] Division of Geriatrics, Department of Medicine, University of California, San Francisco, San Francisco, CA, USA

*Keywords:*
Age-friendly health systems
4 Ms
post-acute care transitions

ABSTRACT

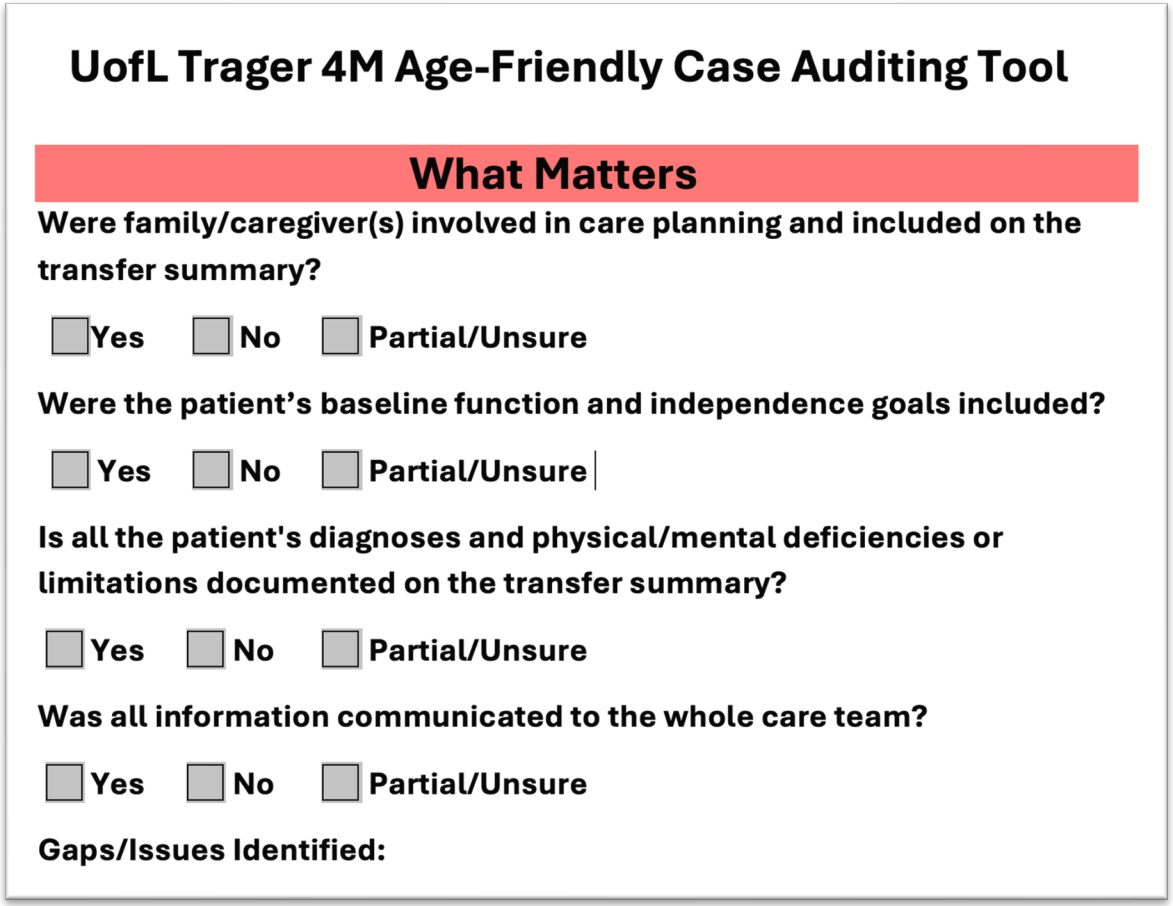
Thousands of health systems have adopted the 4 Ms framework, a set of evidence-based practices specific to older adults, as part of the Age-Friendly Health Systems (AFHS) initiative. However, implementation efforts have largely been setting-specific and approaches to achieve continuity of the 4 Ms during care transitions are nascent. Transitions from hospitals to skilled nursing facilities (SNFs) are one type of care transition that would greatly benefit from continuity of 4 Ms practices. Drawing from the authors' insights and 5 exploratory interviews at 3 health systems that implemented the 4 Ms in the inpatient setting, we describe a set of current-state challenges when trying to extend specific inpatient 4 Ms practices (eg, deprescribing of high-risk medications) as well as the nuanced understanding of the individual's clinical trajectory developed during an inpatient stay. We also offer concrete opportunities, such as developing 4 Ms–centric discharge summary templates, to address the challenges. With the large investment in AFHS transformation and associated efforts to implement the 4 Ms framework in all care settings used by older adults, it is critical to raise awareness of the specific obstacles to promoting continuity of successful 4 Ms practices during care transitions and work to overcome them. Our insights from hospital-to-SNF transitions offer a starting point.

# Action: Care Transitions Audit Tool Draft – What Matters Most

Co-created audit tool by steering committee

Willing to explore the utility of the tool w/different cases

Audit tool led to awareness of need for additional 4Ms training



**UofL Trager 4M Age-Friendly Case Auditing Tool**

**What Matters**

**Were family/caregiver(s) involved in care planning and included on the transfer summary?**

☐ Yes ☐ No ☐ Partial/Unsure

**Were the patient's baseline function and independence goals included?**

☐ Yes ☐ No ☐ Partial/Unsure

**Is all the patient's diagnoses and physical/mental deficiencies or limitations documented on the transfer summary?**

☐ Yes ☐ No ☐ Partial/Unsure

**Was all information communicated to the whole care team?**

☐ Yes ☐ No ☐ Partial/Unsure

**Gaps/Issues Identified:**

# Action: Care Transitions Audit Tool – Other 4Ms

## Medication

Was the medication list with the current dosage attached?

☐ Yes ☐ No ☐ Partial/Unsure

Were any medication changes documented?

☐ Yes ☐ No ☐ Partial/Unsure

Are patient allergies listed?

☐ Yes ☐ No ☐ Partial/Unsure

Was the last/recent dosage of pain medication or antipsychotics documented prior to discharge?

☐ Yes ☐ No ☐ Partial/Unsure

Was a follow-up for high-risk medications arranged and documented?

☐ Yes ☐ No ☐ Partial/Unsure

Was there a medication reconciliation completed prior to di

☐ Yes ☐ No ☐ Partial/Unsure

Was a taper plan for the patients' medications included? W
pending lab or test results documented?

☐ Yes ☐ No ☐ Partial/Unsure

Gaps/Identified

## Mentation

Was a delirium prevention plan included on the discharge summary?

☐ Yes ☐ No ☐ Partial/Unsure

Any noted history of delirium, depression, or dementia included in the transfer summary?

☐ Yes ☐ No ☐ Partial/Unsure

Was a behavioral health follow-up appointment or referral arranged?

☐ Yes ☐ No ☐ Partial/Unsure

Was the patient's mental status documented at discharge?

ial/Unsure

## Mobility

Were fall risk assessments completed and documented?

☐ Yes ☐ No ☐ Partial/Unsure

Were PT/OT referrals or follow-up appointments made and documented in the transition summary?

☐ Yes ☐ No ☐ Partial/Unsure

Was continuity of daily activities documented?

☐ Yes ☐ No ☐ Partial/Unsure

Were assistive devices documented?

☐ Yes ☐ No ☐ Partial/Unsure

Was a home assessment done?

☐ Yes ☐ No ☐ Partial/Unsure

Gaps/Issues Identified:

# Care Transitions Audit Tool – Additional Concerns

## Additional Transition Concerns

**Was a home health referral completed and scheduled prior to discharge?**

☐ Yes ☐ No ☐ Partial/Unsure

**Was a follow-up appointment made and confirmed with PCP and specialist?**

☐ Yes ☐ No ☐ Partial/Unsure

**Was there direct communication between the hospital nurse and the home-health or SNF organization?**

☐ Yes ☐ No ☐ Partial/Unsure

**Gaps/Issues Identified:**

# Lessons Learned

## Successes

- Diverse sector steering committee composition
- Members created vision, mission & goals
- 4Ms training & recognition
- Members working to apply 4Ms to their work
- Greater comfort with 4Ms within and across sectors

## Challenges

- Varied understanding of the 4Ms among committee members
- Inconsistent use of 4Ms language across sectors
- Limited continuity of 4Ms discussion and integration within and between sectors
- Framework adoption is still evolving
- Discharge summaries

## Best Practices

- Provide ongoing, intentional reinforcement of 4Ms concept at each meeting
- Use purposeful repetition and shared language
- Incorporate cross-sector case examples (e.g., fictitious, real)
- Foster peer learning
- Celebrate incremental progress

# Partnership Models & Workforce Development

## Effective Partnership Models

- **Cross-sector collaboration:** Hospitals, nursing homes, home health, and community partners align under shared 4Ms goals.
- **Academic–community partnerships:** University-led support through training, data sharing, and resource development.
- **Steering Committee engagement:** Provides shared leadership and promotes interprofessional trust and accountability.

## Workforce Development Strategies

- **Integrated 4Ms training:** Builds shared language and reinforces age-friendly care across all settings.
- **Train-the-trainer approach:** Expands reach and sustainability through peer champions.
- **Emphasize interdisciplinary learning**
- **Create a continuous improvement culture with** ongoing reflection and audit tools to guide skill strengthening and program adaptation.

# Accomplishing Healthcare Transformation and Competent Care Transitions is a Long Journey

What Does it Look Like?

KIPDA

# Successful Age-Friendly Transitions of Care Model

Applying the 4Ms Framework across the continuum — a case study in coordinated, community-connected care

KIPDA

# The Case: Mrs. Johnson, Age 79

## PATIENT PROFILE

- Admitted for a congestive heart failure exacerbation and a UTI, causing weakness and a fall at home
- History of hypertension, osteoarthritis, and mild cognitive impairment
- Lives alone; her daughter visits several times each week
- Primary goal: recover and remain independent at home

## THE SHARED CHW MODEL

- A Community Health Worker (CHW) is shared between the hospital and the local Area Agency on Aging (AAA)
- Serves as a consistent point of contact for patient and family across every setting
- Engages the patient and daughter before discharge and identifies social determinants of health
- Reinforces the 4Ms care plan and coordinates transportation, nutrition, caregiver support, and home modifications

# The 4Ms Framework in the Hospital

## What Matters

- Goals: return home, attend weekly church, tend her garden, stay independent
- Daughter engaged in a family care conference around these priorities

## Medication

- Comprehensive medication reconciliation completed
- Sedating sleep medication (fall risk) stopped; BP and heart-failure meds adjusted, with rationale documented

## Mentation

- Mild cognitive impairment confirmed at baseline; no delirium
- Delirium prevention: sleep hygiene, orientation cues, early mobility

## Mobility

- Physical and occupational therapy began on hospital day one
- Transfers, endurance, and stairs — goals tied to gardening, shopping, and church

# Transition 1: Hospital → Nursing Home

## Enhanced Discharge Planning

- Interdisciplinary discharge meeting: patient, daughter, nursing, PT/OT, social work, pharmacy, and the CHW
- A standardized 4Ms Transition Summary traveled with her — priorities, baseline cognition, medication changes, mobility goals, fall risk, and social support
- CHW social-needs assessment flagged transportation, home safety, and grocery access — sent ahead to the nursing home

## Seamless Continuation

- Complete 4Ms summary received — care continued without gaps
- **Mentation:** forgetfulness recognized as baseline, not mislabeled
- **Medication:** revised regimen maintained; BP, hydration, and adherence monitored
- **What Matters:** church and gardening goals central to the plan
- **Mobility:** rehab mirrored home tasks — stairs, meals, outdoor walking

# Transition 2: Nursing Home → Home

## Planning for Aging in Place

- Nursing home began transition planning weeks ahead of discharge
- Social worker and CHW engaged the Area Agency on Aging (AAA) and an ADRC specialist in discharge meetings
- Joint needs assessment: transportation, nutrition, home safety, caregiver support, social engagement, and long-term supports
- AAA Case Manager assigned for a warm handoff; coordinated with home health, primary care, and daughter
- A new 4Ms summary was shared with all partners before discharge

## Support in Place at Home

- **What Matters:** AAA arranged rides to church and appointments; senior-center and volunteer resources shared
- **Mentation:** home health, case manager, and daughter educated on baseline cognition and warning signs
- **Medication:** home health nurse reconciled meds; CHW reinforced routines; AAA added reminder and wellness-check services
- **Mobility:** home safety evaluation fixed hazards; AAA obtained grab bars and home modifications

# Outcomes: Six Weeks After Discharge

**0**

**Falls**

**0**

**Hospital Readmissions**

✓

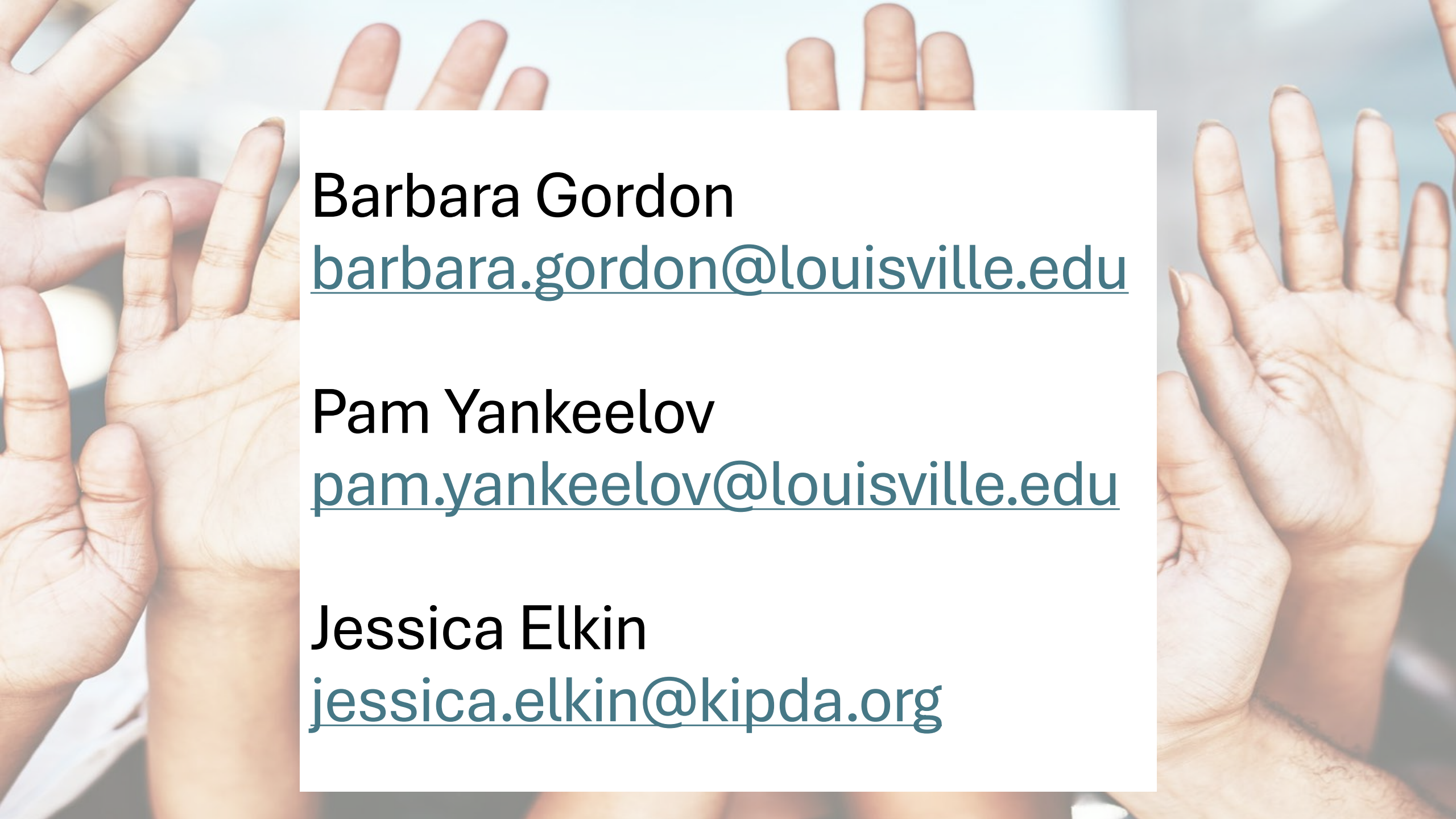
**Living Independently at Home**

- ✓ Stable medication management and symptom control
- ✓ Successful follow-up with primary care and specialists
- ✓ Returned to weekly church attendance
- ✓ Resumed gardening with appropriate modifications
- ✓ Increased confidence managing health conditions
- ✓ High patient and caregiver satisfaction

# Why This Transition Succeeded

1. Standardized 4Ms summary traveled with her at every transition
2. Care Transitions Coordinator ensured continuity across settings
3. Shared Community Health Worker addressed social determinants of health
4. Medication changes and clinical rationale consistently communicated
5. Patient goals and preferences central to every care decision
6. Area Agency on Aging integrated before discharge — proactive, not reactive

Integrating the 4Ms Framework, care-transitions coordination, Community Health Workers, family caregivers, and Area Agencies on Aging builds an age-friendly continuum that reduces risk, improves outcomes, and honors what matters most.



Barbara Gordon
barbara.gordon@louisville.edu

Pam Yankeelov
pam.yankeelov@louisville.edu

Jessica Elkin
jessica.elkin@kipda.org