

Introduction

The 4Ms Framework of an Age-Friendly Health System creates a common language and consistent approach to the care of nursing home residents. Nursing homes have several common structures that can align with the 4Ms: care plan conferences, Quality Assurance and Performance Improvement (QAPI), daily huddles, and stand-up/interdisciplinary team (IDT) meetings. Integrating the 4Ms into regular staff, resident, and family touchpoints centers the 4Ms in daily routines and creates an environment that supports continuously improving resident care.

4Ms in Care Plan Conferences

Hebrew Senior Life (HSL) is New England's largest nonprofit provider of senior health care and living communities. HSL has been part of the AFHS movement since 2020 and has successfully spread the 4Ms across the care continuum. The team's success has been driven by a commitment to ensuring that all staff "buy in" to AFHS and see the 4Ms as a common language that integrates into existing workflows without adding burden. One way the team has accomplished this shared purpose is by using the 4Ms to structure care plan conferences, an effort led by geriatric specialist Dr. Olivia Liff.

How they did it

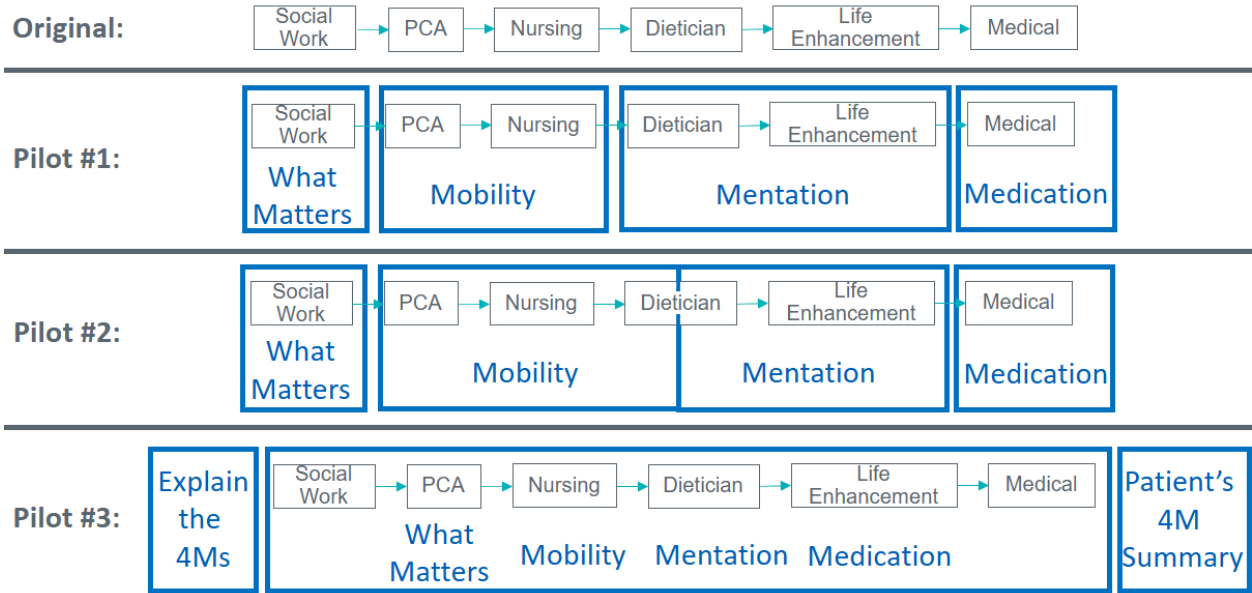
Hebrew Senior Life staff decided to integrate the 4Ms into care plan conferences as a result of work related to What Matters. Dr. Liff reports that the idea came out of the first team meetings to develop an age-friendly implementation plan. Care plan conferences include structure and information that naturally align with the 4Ms. The team saw the care plan conference as an ideal vehicle to discover, discuss, and plan to act on what matters to each resident. They set a goal for 100 percent of care plan meetings to integrate a standardized meeting assessment that uses the 4Ms framework. Using an existing meeting, rather than adding a new one, helps to engage staff and support efficient use of time.

The HSL team decided to pilot 4Ms care plan conferences on Dr. Liff's unit because she is seen by staff as the age-friendly clinician champion. Since the work began in 2024, the team has reported steady improvement in the structure and process of the meeting as well as person-centered documentation structured using the 4Ms. Dr. Liff describes that the next steps include reducing variations across the approaches of conference facilitators and improving the quality of 4Ms documentation.

Staff at Hebrew Senior Life decided to carry out pilot trials, using [Plan, Do, Study, Act \(PDSA\) cycles](#) to test and improve their process:

Pilot Trials

Evolution of 4M Family Care Plan Meeting



Benefits

4Ms-aligned care plan conferences have improved person-centered documentation, a key requirement of the nursing home survey process. Dr. Liff reports that residents, family/caregivers, and staff better understand what to expect when they attend care plan conferences, which helps them to prepare and improves communication. Integrating the 4Ms across the care plan family meetings has centered What Matters in resident care.

Advice for new sites

Dr. Liff recommends that care plan conferences start with an explanation of the 4Ms as an evidence-based framework for person-centered care – meaning that the resident, support persons, and staff are collaborating to determine the best plan of care. This introduction invites residents and support persons to be active participants in the meeting, driving person-centered documentation.

Following the introduction, residents and support persons are invited answer the question “What matters most to you in this chapter?” Interdisciplinary team (IDT) members can then offer a report, connecting Medication, Mentation, and Mobility to What Matters.

At the end, the provider can synthesize goals and plan into a “4Ms Summary” ensuring residents, support persons, and team members all have a shared understanding of the focus moving forward. It is vital to include all relevant IDT members from the beginning. The HSL team includes social workers, life enhancement specialists, dietitians, clinicians, nurses, and physical and occupational therapists. All departments are involved in providing 4Ms care.

4Ms in QAPI

Presbyterian Senior Care Network (PSCN) is one of a select group of post-acute/long term care communities that were early participants in the Teaching Nursing Home Collaborative based in Pennsylvania. As part of the Collaborative, participants implemented age-friendly care. Now in its third year of this work, PSCN has found innovative ways to engage the entire community – residents, family/caregivers, and staff – to grow and sustain an age-friendly community.

How they did it

Taylor McMahon, Director of Nursing at PSCN, shared how PSCN structured its QAPI approach according to AFHS principles. The IDT team meets weekly – certified nursing assistants (CNAs), nurses, physicians, recreation /music therapists, social workers, wound care nurses, and therapists – by **visiting from neighborhood to neighborhood**. The psychologist and consulting pharmacist also attend monthly. Each resident’s care is reviewed and planned using the 4Ms. These on-unit rounds allow for timely updates to care plans and also inform quarterly QAPI. Like weekly IDT meetings, quarterly QAPI also is interdisciplinary, and always includes CNAs.

Benefits

During weekly rounds, residents are encouraged to start by talking about what matters. For example, one seriously ill resident stated that she didn’t want any more injections. As the team gathered more information, they verified that the resident wanted a more palliative or comfort-focused approach to care. To support what mattered most to the resident, the team transitioned her to oral medications for her diabetes and discontinued injected insulin and routine capillary sticks for blood glucose monitoring. A what matters issue identified by one resident often reveals patterns that can be addressed across the resident population and can be measured to ensure concordance between what matters and the care received.

In another example, a resident screened positive for depression symptoms on the PHQ-9 and the social worker followed up. The systematic follow-up for the positive PHQ-9 score was part of an earlier, nursing home community-wide performance improvement project (PIP). The team created a protocol that prompts a social work visit within one week, and then a follow-up 4Ms review with the team. In this example, the social worker began by asking the resident about what matters to her. The resident shared that music mattered most to her. The music therapist set up piano lessons, including a keyboard in the resident’s room. In this case, the positive PHQ-9 score led to an individual care plan for that resident. In addition, a medication review revealed that the resident’s antidepressant had been at the same dose for 10 years. The provider adjusted the dose to reach a therapeutic level. The social worker and activities staff met with the resident bi-weekly for a period of time to ensure the care plan was implemented and adjusted as needed. Within five weeks, the resident’s PHQ-9 score and depression symptoms improved. Taylor stressed the importance of interdisciplinary collaboration to integrate age-friendly principles in the community’s QAPI approach. She stressed that there are no observers on the team: “Everyone has a voice and walks away with a job.”

Advice for new sites

Taylor says that progress has been steady in building the 4Ms into the culture. The improvement her team has seen in resident satisfaction and outcomes and staff engagement have been transformational. For sites considering AFHS or just getting started, she says: “The 4Ms bring purpose to practice – enhancing the quality

of care, inspiring teams, and fostering communities where every older adult can thrive. I encourage you to continue your age-friendly journey and experience the lasting impact of 4M care on residents, staff, and families alike.”

4Ms in Stand-up and IDT Meetings

The US Department of Veterans Affairs (VA) is committed to spreading age-friendly care throughout their health care facilities. This includes Community Living Centers (CLCs), which are VA nursing homes. The North Florida/South Georgia Veterans Health System CLC located in Gainesville, Florida implemented the 4Ms with a focus on using the framework in their weekly IDT meetings. The initial effort was led by Dr. Laurence Solberg, the Associate Director of Clinical Innovations at the Gainesville Geriatric Research, Education, and Clinical Center. The IDT meeting is now led by the CLC Director and the medical team.

How they did it

Dr. Solberg led by introducing AFHS and the 4Ms to the IDT to efficiently organize care around What Matters to veterans. Team engagement was critical to success. The team started with a unit of about 25 veterans. Stand-up meetings are part of nursing home culture and often require considerable staff time to discuss each resident’s current issues and needs. Dr. Solberg saw an opportunity to streamline these discussions that often “meander a bit.” The team focused on guiding conversations using the 4Ms Framework for every veteran. Discussing each M helped to keep the meeting on track.

Benefits

The Gainesville CLC team spent about 6 hours per week in stand-up meetings. 4Ms-aligned discussions reduced this to 2 hours per week. This time savings is striking. Dr. Solberg reports that “those four hours are now given back to patient care for our veterans.”

Advice for new sites

Dr. Solberg advises nursing homes to assess what they already do first, because much of current care practices already align with the 4Ms. Use the 4Ms Framework to tie everything together, identify gaps, and move toward improvement. Read more about the Gainesville CLC team’s journey in this blog post: [Centering What Matters: The Core of Age-Friendly Care](#).