Institute *for* Healthcare Improvement

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Age-Friendly Health Systems:

A Workbook for Nursing Home Teams

A Companion Resource to the

Age-Friendly Health Systems: Guide to Care of Older Adults in Nursing Homes

This content was created especially for:

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).

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Learn more at ihi.org/AgeFriendly.

To provide feedback on the Workbook or other resources, ask questions, share progress, or learn more about **Age-Friendly Health Systems Care of Older Adults in Nursing Homes**, please email Alice Bonner (abonner@ihi.org) or AFHS@ihi.org.

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For additional tips, charts, and examples, please review the

Age-Friendly Health Systems: Guide to Care of Older Adults in Nursing Homes.

Introduction

Designed to be practical and easy to use in daily practice, this Age-Friendly Health Systems: **A Workbook for Nursing Home Teams** is a step-by-step resource for people providing care to residents in nursing homes. It is a companion to the Age-Friendly Health Systems: **Guide to Care of Older Adults in Nursing Homes** and designed to be used together to help care teams prepare for, test, and implement a specific set of evidence-based or evidence-informed age-friendly practices referred to as the 4Ms Framework.

Both the Workbook and Guide outline the 4Ms for nursing home care of older adults, including post-acute and long-term care settings (e.g., skilled nursing and rehabilitation facilities [SNFs] and nursing facilities [NFs]), hereafter referred to collectively as nursing homes).

- This Workbook includes printable worksheets that team members (including certified nursing assistants or CNAs) working directly with individual residents may use to deliver 4Ms age-friendly care. The Workbook was developed with expert faculty and advisors, five pioneering health systems, ten nursing homes, and other partners.
- The Guide provides recommendations for how to implement a series of actions system-wide (throughout the nursing home or campus). It also provides recommendations for how to build the will for change and how to communicate about the 4Ms to all residents, care partners, and staff members to engage the entire community in promoting age-friendly care.

Age-Friendly Health Systems Overview

The United States population is aging. The number of older adults ages 65 years and older is growing rapidly. As we age, care often becomes more complex. Health systems are frequently unprepared for this complexity, and older adults experience a disproportionate amount of harm while receiving care in the health system.

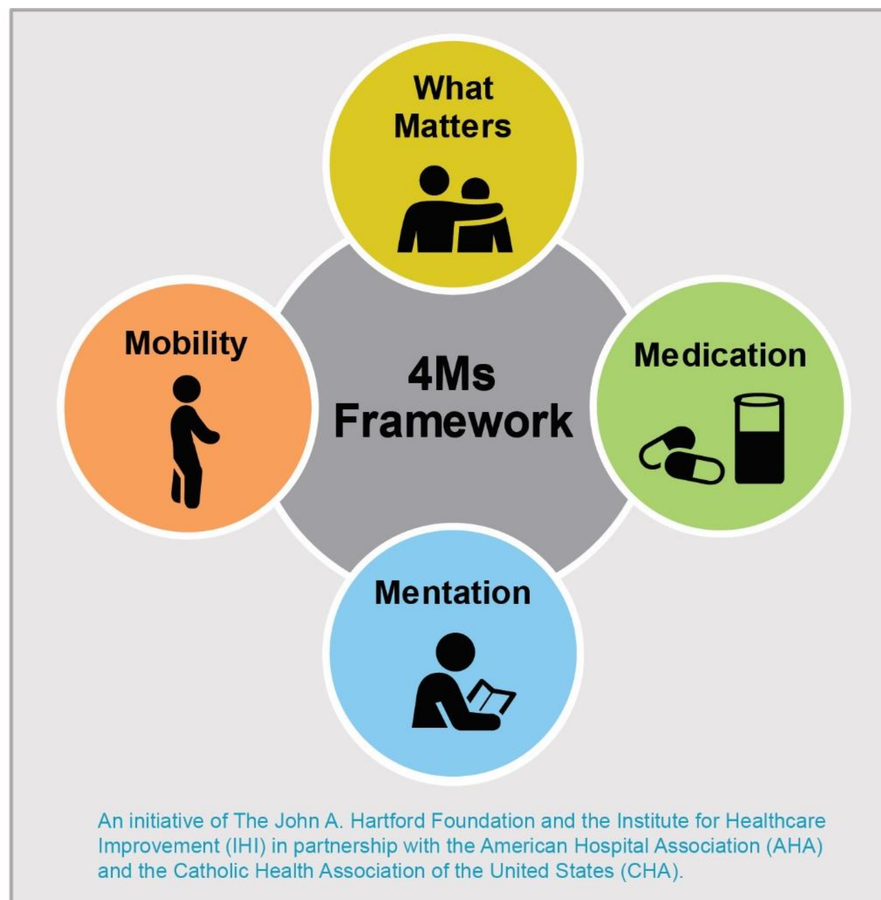
According to our definition, age-friendly care:

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

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

Nursing homes have a unique and important role in caring for older adults. In addition to clinical care, nursing home staff are expected to help provide a safe, enjoyable life experience in a home-like setting. The 4Ms provide an important opportunity to bring meaning and joy to residents and the staff who work with and support them.

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



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, advance care planning and goals of 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.

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

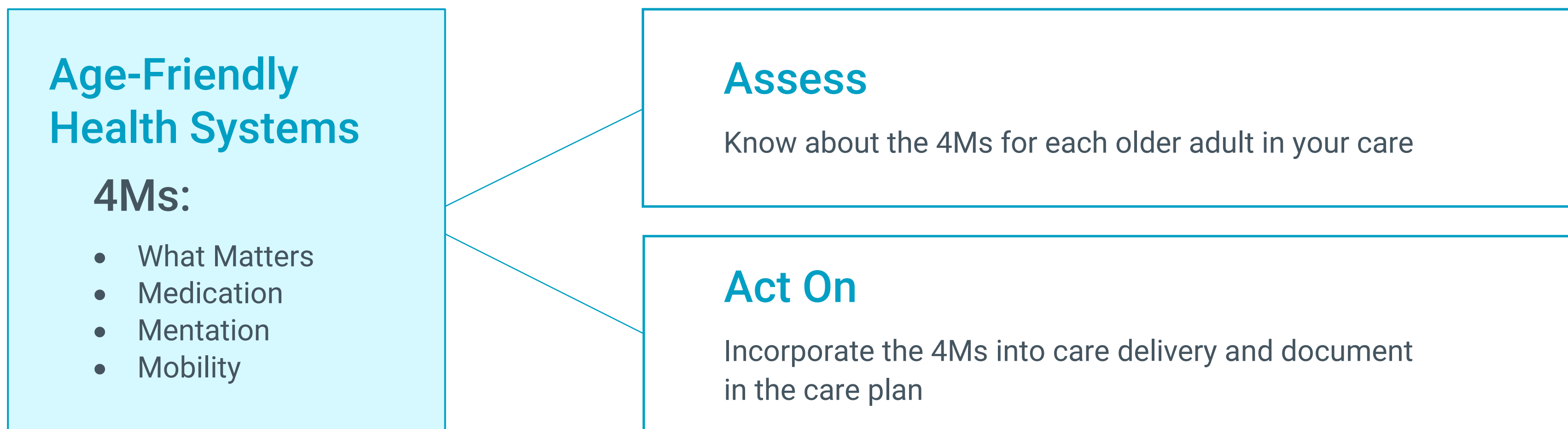
4Ms Framework: Not a Program, But a Shift in Care

- The 4Ms Framework is not a program, but a shift in how we provide care to and with 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 nursing home 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 (i.e., for all older adults, in all settings and across settings, in every interaction).

Key Drivers of Age-Friendly Care

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 documenting 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



Putting the 4Ms into Practice for Each Resident

A plan for integrating the 4Ms into care for each nursing home resident has a number of steps. The pages that follow correspond to each step and provide templates (worksheets) for some steps for your team to use in daily practice.

Step 1/Worksheet 1. Assemble and Prepare the Team; Begin to Outline an Approach

- Select one or two units (your organization may refer to these as neighborhoods, floors, or communities) to start the implementation process.
- Identify team members on the selected unit(s). [Guidance on putting together an improvement team is included below.]
- Arrange days, times, and locations to meet, based on input from team members.
- Determine how to communicate with residents, nursing home staff, and other stakeholders about age-friendly care and the 4Ms in order to promote everyone's engagement and support.

Step 2/Worksheet 2. Review, Discuss, and Understand Current 4Ms Goals, Practices, and Workflows on the Unit (4Ms Care Descriptions)

- Describe goals and practices for 4Ms care on the unit that the team plans to test, adapt, and implement going forward.

Step 3/Worksheet 3. Sequence the Process: Start with One Resident and One "M," Then Test Remaining Three "Ms"

- Start by providing care to one resident focused on one of the "Ms."
- Add the remaining three "Ms" until the team has completed all 4Ms as a set with one resident.
- Continue with two to five additional residents using similar processes.

Step 4/Worksheet 4. Integrate the 4Ms as a Set for Each Resident and for the Unit as a Whole

- The team reflects on how to expand 4Ms care for each resident and next steps to integrate 4Ms care into team workflows.

Step 5. Next Steps: Improve and Sustain 4Ms Care (no worksheet)

Below is a suggested timeline for implementing the 4Ms. Based on others' experiences, this may be a reasonable timeline for starting to implement the 4Ms in your nursing home. Your experience may vary, depending on how much of this work you are already doing and other priorities you are working on. You may want to put the steps and timelines below into a calendar for the next 4 to 6 months.

Steps in the 4Ms Implementation Process	Estimated Time
Step 1. Assemble and Prepare the Team; Begin to Outline an Approach	4 to 7 weeks
Step 2. Review, Discuss, and Understand 4Ms Goals, Practices, and Workflows on the Unit (4Ms Care Descriptions)	2 to 3 weeks
Step 3. Sequence the Process: Start with One Resident and One "M," Then Test Remaining Three "Ms"	1 to 2 weeks
Step 4. Integrate the 4Ms as a Set for Each Resident and for the Unit as a Whole	2 to 4 weeks [One "M"] 6 to 8 weeks [Remaining Three "Ms"]
Step 5. Next Steps: Improve and Sustain 4Ms Care	1 to 2 weeks
Estimated Total Time:	16 to 26 weeks

You may be asking, "Why does this look like it takes so long?"

The answer is that there are a number of things happening as you go through this process. You are creating space for your team — managers and direct care staff — to work together as a team, think differently, and experiment with new ways of doing work that bring meaning and joy to residents' lives and staff work. You are likely busy with many things, so this effort is designed to incorporate what you are already doing rather than creating additional work. And, with many things that are interesting and meaningful, it may seem like a lot at first and then you find that time flies. The estimated timeline above is simply a guide — each team may be flexible with each step.

"At the beginning we thought this would take forever and then we realized the time had gone by and we had arrived."
—Nursing Home Participant

This should take approximately one to two team meetings (weeks) to complete.

Step 1/Worksheet 1

Assemble and Prepare the Team; Begin to Outline an Approach

Select the Unit(s)

Select one or two units to start the 4Ms implementation process.

Name of unit(s) within the nursing home where 4Ms age-friendly care will be used:

____

Assemble the Team

Identify Team Members

Based on our experience, teams that include certain roles or functions are most likely to succeed. CNAs should always be included on the team.

Please review the roles in the table below and then use the form that follows to identify members of your team.

Role	Name	Contact Info (phone, email)	Best Day(s)/ Time(s) to Meet	Best Location to Meet	Notes
Leader/Sponsor					
Unit Manager/Supervisor					

Interprofessionals, including Clinicians and Others Representing Disciplines Involved in the 4Ms (list all, including RNs, MDs, NPs, PAs, Pharmacists, Nutrition Professionals, PTs, OTs, SWs, CNAs, Environmental Services, Mental/Behavioral Health Providers, Others)					
Resident*					
Care Partner*					
Others					

*Residents and their care partners may only participate in their own Care Plan Meetings, not meetings in which other residents will be discussed.

Notes and Ideas:

Team Member Roles	Description
Leader/Sponsor Identifying this person is vital to the success of Age-Friendly Health Systems	This person champions, authorizes, and supports team activities, as well as engages senior leaders and other groups within the nursing home to remove barriers and support implementation and scale-up efforts. Although the person 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) and data, are available to the team • Developing a plan to scale up successful changes from the improvement team to the rest of the organization
Unit Manager/Supervisor	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 the manager of the unit where changes are being tested is in this role because that individual can likely move nimbly to take necessary action, make recommended changes in that unit, 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), physical, occupational or speech therapist, social worker, care manager, pharmacist, chaplain, nutrition professional, environmental services workers, 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 clinician 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 people who are opinion leaders in the organization, who others seek for guidance, who are close to the point-of-care, and who are not afraid to test and implement change.

<table>
<tr>
<td>An Older Adult (Resident) and Care Partner

(Residents and care partners may only attend calls or meetings related to their own care/care planning, not those of other residents.)</td>
<td>Older adults and families or care partners bring critical expertise to any improvement team. They have a different experience with the nursing home than providers and can often identify key issues. Each team should have at least one older adult or family member/care partner (ideally more than one), or a way to elicit feedback directly from those individuals (e.g., through a Resident and/or Family Advisory Council).

Additional information about appropriately engaging older adults and care partners in improvement efforts can be found on the Institute for Patient- and Family-Centered Care website and Valuing Lived Experience: Why Science Is Not Enough.</td>
</tr>
<tr>
<td>Others</td>
<td>• Improvement coach
• Data analyst/EHR analyst
• MDS Coordinator; Registered Nurse Assessment Coordinator
• Finance representative
• Consider payers or insurers (e.g., care navigators or care managers), ACO representatives, hospital or health system representatives (to address potential issues during care transitions)
• Students (with faculty) from health professions, public health, or other educational programs</td>
</tr>
</table>

This should take approximately one to two team meetings (weeks) to complete.

Arrange Days, Times, and Locations for the Team to Meet

Days of the Week and Times

Ask team members which days of the week and times are most convenient for them to attend the meetings (e.g., CNAs, nurses who provide direct care, social workers, activities director, pharmacists, primary care clinicians, behavioral health providers). Consider rotating days/times to accommodate schedules.

Proposed day(s) of the week/time(s): ____

Meeting Locations

Ask team members about the most convenient place for them to meet (e.g., conference room on the unit, away from the unit, etc.).

Proposed location(s): ____

Additional Considerations

- Consider including certain team members who may be off-site, such as pharmacists, behavioral health providers, or medical directors, by phone or computer.
- Consider how to engage residents and care partners in age-friendly care discussions on that resident's care plan.
- Provide resident care coverage as much as possible so that CNAs, nurses, and other direct care workers or interested staff may attend age-friendly care meetings.
- Develop or adapt standard written or electronic tools for documenting Age-Friendly Health System discussions, goal and care plan updates, EHR notes, and next steps. Provide access to this information for all clinicians, including CNAs.

Notes and Ideas:

This should take approximately two to three weeks to complete.

Communication Approaches: Getting the Word Out

"We wish we would have had more opportunities to let people know about the journey we were starting. It could have helped us get stronger buy-in earlier on." —Nursing Home Administrator

Communicating about the team's work to implement 4Ms care for residents is a good way to get buy-in from the staff on the unit(s) initially selected for testing these ideas, in addition to building awareness throughout the nursing home among staff who will be engaged in this work going forward.

Below are some approaches to communicate about this work:

- Review and revise any slides and/or handouts, if you plan to use them.
- Choose times and speakers for the presentation(s).
- Share the presentations and get feedback from staff and residents. **Include actual stories about how 4Ms care has made a difference to a resident, staff member, or both.** Discuss and document feedback from the team meeting.
- Schedule the next communication event(s). Invite anyone else interested to join this or future improvement teams.

Notes and Ideas:

This should take approximately two to three team meetings (weeks) to complete.

Step 2/Worksheet 2

Review, Discuss, and Understand Current 4Ms Goals, Practices, and Workflows on the Unit (4Ms Care Descriptions)

It is important preparation work for the team to understand:

- **Who is assessing** each of the 4Ms: What Matters, Medication, Mentation, Mobility
- **What assessment tools** they are using
- **How each of the 4Ms is acted on**
- **Where each of the 4Ms is documented, and how each team member can access that information**

This will help the team try new things and understand what the nursing home is already doing to integrate all 4Ms into resident care.

Your team may not know all of this information yet! The goal is to document what the team currently knows, and by the time you have implemented all of the 4Ms, the worksheets below will be completed, documenting the changes that have been put in place.

Complete the forms below for each of the 4Ms: What Matters, Medication, Mentation, Mobility.

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences, including all stages of health and across settings of care.

Who is assessing?	What tools are being used?	How frequently is it assessed?	How do you act on What Matters?	Where do you document this?	Notes
☐ Nurse ☐ Social Worker ☐ MD/NP/PA ☐ Care manager ☐ Other: _____________	List the question(s) you ask to know and align care with each older adult's specific health and related goals and care preferences:	☐ Upon admission and once per stay (at least annually) ☐ Review with quarterly MDS and care plan meetings ☐ Daily, if condition unstable or new diagnosis/es ☐ Other: _____________	☐ Align the care plan with What Matters most to the older adult ☐ Brainstorm with the older adult about specific activities and/or preferences to integrate What Matters to them into daily routines ☐ Other: _____________	☐ EHR ☐ Care Plan ☐ Other: _____________	Consider ways to monitor whether what is in the care plan (What Matters to the resident) is actually provided to the resident

Medications

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

Who is assessing?	What Medications are being assessed?	How frequently is it assessed?	How do you act on Medications?	Where do you document this?	Notes
☐ Nurse ☐ MD/NP/PA ☐ Pharmacist ☐ Other: ___________	Check the medications you screen for regularly: ☐ Benzodiazepines or other anxiolytics ☐ Opioids ☐ Highly-anticholinergic medications (e.g., diphenhydramine) ☐ All prescription and over-the-counter sedatives and sleep medications ☐ Muscle relaxants ☐ Tricyclic or other antidepressants ☐ Antipsychotics, neuroleptics ☐ Mood stabilizers ☐ Other (consider sliding scale insulin, aspirin, proton pump inhibitors or PPIs, or other potentially high-risk medications): ___________	☐ Upon admission and at least once per stay ☐ Daily, if condition unstable or new, potentially serious diagnosis/es or medications are added (consider duration of order, particularly for psycho-active medications and opioids) ☐ Other: _____________	☐ Educate residents, care partners, staff ☐ Deprescribe (includes both dose reduction and medication discontinuation) ☐ Pharmacist consult __________ ☐ Include CNAs and other staff in communicating about change in condition that could be related to medications ☐ Confer with resident and care partners ☐ Other: _____________	☐ EHR ☐ Care Plan ☐ Pharmacy records/MAR ☐ Other: ____________	Consider ability for each team member to access documentation by other disciplines in the record

Mentation — Dementia

Identify and manage (Assess and Act On) dementia and related behaviors.

Who is assessing?	What tools are being used?	How frequently is it assessed?	How do you act on Mentation — Dementia?	Where do you document this?	Notes
☐ Nurse ☐ Social Worker ☐ MD/NP/PA ☐ Behavioral/ mental health consult ☐ Other: ___________	Check the tools used to screen or assess for dementia: ☐ Mini-Cog (screen) ☐ SLUMS (assess) ☐ MOCA (assess) ☐ MMSE (assess) ☐ Other: _____________	☐ Upon admission and with change in condition ☐ Other: _____________	☐ Educate resident and care partners ☐ Prevent and mitigate unsafe behaviors r/t dementia ☐ Refer to professional organization for education and/or support	☐ EHR ☐ Care Plan ☐ Other: _____________	Consider ability for each team member to access documentation by other disciplines in the record

Mentation — Depression

Identify and manage (Assess and Act On) depression and related behaviors.

Who is assessing?	What tools are being used?	How frequently is it assessed?	How do you act on Mentation — Depression?	Where do you document this?	Notes
☐ Nurse ☐ Social Worker ☐ MD/NP/PA ☐ Behavioral/ mental health consult ☐ Other: __________	Check the tools used to screen for depression: ☐ PHQ-2 ☐ PHQ-9 ☐ Geriatric Depression Scale (GDS) or short form	☐ On admission and with change in mood or condition ☐ Other: __________	☐ Educate resident and care partners ☐ Prevent and mitigate unsafe behaviors r/t depression ☐ Refer to professional organization for education and/or support	☐ EHR ☐ Care Plan ☐ Other: __________	Consider ability for each team member to access documentation by other disciplines in the record

Mentation — Delirium

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

Who is assessing?	What tools are being used?	How frequently is it assessed?	How do you act on Mentation — Delirium?	Where do you document this?	Notes
☐ Nurse ☐ MD/NP/PA ☐ Other: ___________	Check the tools used to screen for delirium: ☐ UB-2 or UB-CAM ☐ CAM ☐ Other: _____________	☐ Every 24 hours or with change in condition for delirium in SNF; with change in condition or as needed in NF	Delirium prevention and management protocol, including but not limited to: ☐ Investigate potential underlying medical conditions/causes ☐ Ensure sufficient oral hydration ☐ Orient older adult to time, place, and situation on every nursing shift if/when appropriate ☐ Ensure that older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers) ☐ Prevent sleep interruptions; use non-pharmacological interventions to support sleep ☐ Avoid high-risk medications; monitor for adverse drug events ☐ Other: ____________	☐ EHR ☐ Care Plan, including behavioral care plan ☐ Other: _____________	Consider consultation with pharmacist Consider ability for each team member to access documentation by other disciplines in the record

Mobility

Ensure that each older adult moves optimally every day to maintain or improve function and to do What Matters.

Who is assessing?	What tools are being used?	How frequently is it assessed?	How do you act on Mobility?	Where do you document this?	Notes
☐ Nurse ☐ MD/NP/PA ☐ PT ☐ OT ☐ Other: ___________	Check the tools used to screen for mobility: ☐ Timed Up & Go (TUG) ☐ JH-HLM ☐ POMA ☐ Other: _____________	☐ Once per stay and with change in condition or function ☐ With quarterly MDS review and care planning ☐ Daily ☐ Other: _____________	☐ Ambulate 2 to 3 times a day or as directed ☐ Out of bed or leave room for meals if appropriate ☐ Physical therapy (PT) intervention (balance, strength, gait, gait training, exercise program) ☐ Avoid physical and chemical restraints ☐ Remove catheters and other tethering devices ☐ Avoid high-risk medications ☐ Multifactorial fall prevention protocol (e.g., STEADI or others) ☐ Educate older adult and care partners ☐ Manage conditions that reduce mobility (e.g., pain, balance, gait, strength) ☐ Ensure safe environment for mobility ☐ Identify and set a daily mobility goal with older adult that supports What Matters; review and support progress toward the goal ☐ Other: ____________________	☐ EHR ☐ Care Plan ☐ Other: _____________	Consider ability for each team member to access documentation by other disciplines in the record

"I thought that we were already doing most of these things. We just didn't call it 'age-friendly.' After doing the Process Walk-Through, we found out that we weren't as consistent or reliable as we thought. That helped the team understand the opportunities in front of us and how to build on what we already do." —Nursing Home Staff Nurse

How are the 4Ms currently practiced on the selected unit(s) of the nursing home?

- Walk through daily routines and activities, from admission to the first few weeks to longer-term (e.g., next quarter), as if you are an older adult or care partner.
- Sit quietly in common spaces such as halls and look for the 4Ms in action.
- Observe the workflow and look for gaps or duplication of efforts.
- Find and recognize bright spots, opportunities, and champions of each of the 4Ms in your system.

Here are some questions to consider, from a resident's perspective:

- Did care team members ask about What Matters to you?
- Are your goals, routines, and preferences being acknowledged and followed?
- Do you have enough information to make decisions about your care and lifestyle choices?
- Do you feel safe?
- Are you moving around if you are able to? If not, why not?
- Do you know the medications that you are taking, and understand what they are for?
- How do you feel about being here?
- What else can staff do that would make your life better?

From a staff member's perspective:

- Are care team members paying attention to residents' concerns?
- Are What Matters, Medication, Mentation, and Mobility (the 4Ms) being considered when putting together the care plan? What is going well? What is missing?

Respond to the questions below to understand your unit's current 4Ms practices and workflows.

- ☐ What are current daily routines or activities and services related to each of the 4Ms that the team currently incorporates? For example, does someone on the team ask about What Matters? Does someone on the team review for high-risk medication use? Does someone on the team screen for delirium, depression, dementia, mobility? How reliably are these actions practiced?

- ☐ What processes, tools, and resources to support the 4Ms are already in place here or elsewhere in the system?

- ☐ Where is the 4Ms prompt or documentation available in the written records, EHR, or elsewhere for all clinicians and care team members? Is there a place to see the 4Ms (individually and/or together) that is accessible to all team members? Across settings? Easy to access for all team members, including CNAs?

- ☐ What experience do your team members have with the 4Ms? 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, community-based, or other 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? If so, in what ways?

- ☐ Which languages do older adults and their care partners speak? Read? Are cultural or religious backgrounds noted?

- ☐ Do the health literacy levels, language skills, and cultural preferences of older adults match the assets of your team and the resources provided by your nursing home?

- ☐ What works well?

- ☐ Where are the gaps? What could be improved?

Notes and Ideas:

Implementing all 4Ms with one resident may take three to four weeks, sometimes less.

Step 3/Worksheet 3

Sequence the Process: Start with One Resident and One “M,” Then Test Remaining Three “Ms”

“At first we thought this was going to be a lot of work. By starting small with one resident and trying new things, we were able to see the results and build on them, and then we kept building and realized it was possible and the staff and residents got a lot out of it.” —Nursing Home Partner

Tip: Use information from Worksheet 2 to help you decide how to assess and act on each “M.”

Start with inviting a resident to participate. Provide care to one resident focused on one of the 4Ms.

- Describe why you are starting with this particular resident.
- Describe why you are starting with this “M” with this resident.
- Describe how you will assess the “M.”
- Describe how you will act on the “M” assessment.
- Describe how this “M” may impact one or more of the other three “Ms.”
- Describe where the team documents the work and who has access to the information.
- Use information or data to review what happened (what worked/what didn’t work). Consider how this may tie in with QAPI and “The Five Whys” or other quality principles.
- Adjust the team’s approach to address what didn’t work and try again.

Once you have documented your test for one “M,” continue testing the remaining three “Ms” with the same resident.

Select One Resident and One "M"

Test implementing one "M" with one resident and document your notes in the form below. (See below for an example.)

Resident name	
Why this resident is participating (why selected)	
Which "M" was selected first and why	
How was the "M" assessed?	
How was the "M" acted on?	
What happened when we tried it (over what period of time)? How did the resident respond?	
What did we change as a result to make it work?	
Where does the team document this work?	
Other notes	

Allow 2 to 3 weeks to continue testing the three remaining “Ms” with the same resident.

Test the Remaining Three “Ms” with the Same Resident

Continue the process to **test the remaining three “Ms” with the same resident** and document your notes in the forms below. (See below for an example.)

Resident name	
Which “M” was selected and why	
How was the “M” assessed?	
How was the “M” acted on?	
What happened when we tried it (over what period of time)? How did the resident respond?	
What did we change as a result to make it work?	
Where does the team document this work?	
How did this “M” interact/work with the others?	
Other notes	

Resident name	
Which “M” was selected and why	
How was the “M” assessed?	
How was the “M” acted on?	
What happened when we tried it (over what period of time)? How did the resident respond?	
What did we change as a result to make it work?	
Where does the team document this work?	
How did this “M” interact/work with the others?	
Other notes	

Resident name	
Which “M” was selected and why	
How was the “M” assessed?	
How was the “M” acted on?	
What happened when we tried it (over what period of time)? How did the resident respond?	
What did we change as a result to make it work?	
Where does the team document this work?	
How did this “M” interact/work with the others?	
Other notes	

Once all 4Ms have been tested with one resident, continue testing the 4Ms with two to five additional residents using similar processes.

Example

Below is an example of how a nursing home completed the worksheet for implementing the 4Ms (the process) for one resident.

Resident name	Mr. T
Why we worked with this resident	He doesn't seem to engage much with anyone
Which "M" was selected and why?	**What Matters:** We wanted to find out what is important to Mr. T and what he might be interested in.
How was the "M" assessed?	Mr. T's primary CNA asked him, "What makes a great day for you?" and about activities he enjoyed before he came to the nursing home, what kinds of social events he used to participate in, what foods he likes, his music preferences, his family and friends, and what kind of exercise or moving around he used to do.
How was the "M" acted on?	Among many things, we learned he liked listening to rock and roll music, plays the guitar, and once belonged to a band. We identified another resident, Mr. V, who was also interested in rock and roll music and had played the drums. We asked if they would like to start a rock and roll listening club and they agreed to try it.
What happened when we tried it? How did the resident respond?	• Week 1: We found a time for Mr. T and Mr. V to meet. They met once but Mr. V needed assistance to get to the meeting and staff was not available the next time they planned to meet. • Week 2: We asked Mr. T to be in charge of getting to Mr. V's location, so he arranged to get himself to Mr. V's household and they planned a series of meetings with arrangements for staff assistance with transport in place. • Week 3: Mr. T and Mr. V are working on a playlist for their households and working with activities staff to play the music at specific days/time.
What did we changed as a result to make it work?	Staff assistance with transport to another location improved to support What Matters to Mr. T and other residents
Where the team documents this work	Mr. T's care plan, CNA care cards
Other notes	See the remaining 3 "Ms" described below

Keep reading below to see how the team approached the remaining three “Ms” for Mr. T in a sequence chosen by the team, following Mr. T’s own goals and What Matters to Mr. T.

Resident name	Mr. T
Which “M” was selected and why	**Mentation:** Social work brought the last PHQ-9 and SLUMS screens from the MDS to the team. There was no evidence of depression, delirium, or dementia; however, based on his history and risk profile, the team decided to re-assess and monitor for depression.
How was the “M” assessed?	The social worker conducted the PHQ-9 on Mr. T and did not find depression, but Mr. T did say he was feeling better working on their music project.
How was the “M” acted on?	The team chose to continue working with Mr. T on What Matters and discuss at the next care plan meeting. They also reassessed his Mentation on a regular basis.
What happened when we tried it? How did the resident respond?	The team developed a better sense of Mr. T’s moods and sense of well-being.
What did we change as a result to make it work?	We decided to continue monitoring Mr. T for depression and possible interventions.
Where does the team document this work?	Care plans, CNA care cards
How did this “M” interact/work with the others?	Depression assessment by the team linked back to the What Matters conversations and documentation
Other notes	

Resident name	Mr. T
Which "M" was selected and why	**Mobility:** Mr. T had been moving more as he organized his music program, but we thought there might still be more opportunity for movement.
How was the "M" assessed?	We used the Johns Hopkins Highest Level of Mobility (JH-HLM) mobility scale to assess where he was and some potential mobility goals of care, and asked Mr. T if there were any activities or exercise he'd like to participate in. He said he had done a tai chi program before he came to the nursing home and would be interested in trying that again.
How was the "M" acted on?	The therapeutic recreation/activities director started a tai chi class for three to four residents, including Mr. T, who were interested in trying it.
What happened when we tried it? How did the resident respond?	• Week 1: Three of the four residents attended the tai chi class and all decided to continue. The recreational therapy director was able to play a YouTube tai chi class video for everyone who was interested. • Week 2: The two residents continued the tai chi video class and wanted to do it more than once a week, so the activities director put together an additional time. • Week 3: The two residents continued and two more joined the class as they had been observing it.
What did we change as a result to make it work?	Increased offering of tai chi program to residents, including Mr. T
Where does the team document this work?	Care plans, CNA care cards, therapy notes
How did this "M" interact/work with the others?	Increased activity that Mr. T enjoys contributes to positive mood and sense of well-being, more social interaction among residents
Other notes	

Resident name	Mr. T
Which "M" was selected and why	**Medication:** We chose Medication as the 4th "M" to assess with Mr. T, to time with his regularly scheduled MDS medication review.
How was the "M" assessed?	We met with the pharmacist and reviewed Mr. T's medications through the 4Ms lens: Were there any medications on the high-risk list that needed to be revisited? Were there other medications that cause difficulty with Mobility, Mentation, or getting in the way of What Matters to Mr. T?
How was the "M" acted on?	We determined that Mr. T's medication regimen was acceptable and no changes were required at this time. This was documented in the EHR.
What happened when we tried it? How did the resident respond?	Engaged the team in thinking about medications that might impact the other 3 "Ms" or other aspects of Mr. T's quality of life
What did we change as a result to make it work?	All medications reviewed, no changes at this time
Where does the team document this work?	Care plans, CNA care cards
How did this "M" interact/work with the others?	Medication review with the pharmacist confirmed that Mr. T.'s medication regimen seems to support the other 3 "Ms" and his overall health and well-being. This standardized medication review may be included in the QAPI policies and procedures to support a systems approach.
Other notes	

Step 4/Worksheet 4
Integrate the 4Ms as a Set for Each Resident and for the Unit as a Whole

This step should take one to two team meetings.

Once you have implemented all 4Ms for one resident or several residents on the selected unit(s) (or you might refer to these as neighborhoods), ask yourselves these questions as a team:

- How do we observe the 4Ms working together (note specific observations)?
- Is there one "M" that seems to drive the others? If so, which one? If not, what do you see instead?
- How do you plan to capture in one place how all 4Ms are working together for each resident so that you can adjust and observe over time?

Some nursing homes are adding a section to the Person-Centered Care Plan that details the 4Ms in one place so the interprofessional team can work together to sustain the 4Ms over time.

- Would this work for your team? Why or why not?
- What is your plan to document and adjust the 4Ms over time?

Step 5

Next Steps: Improve and Sustain 4Ms Care

Becoming an Age-Friendly Health Systems Nursing Home

Congratulations! You are on your way to becoming an Age-Friendly Health Systems Nursing Home. Your nursing home team has gone through several weeks of planning and preparation, observations, experimentation and testing, and learning about age-friendly practices in your nursing home.

Consider your next steps:

- Now that the team has implemented the 4Ms with at least one resident and one or more staff members on at least one unit, it is time to consider how to further scale and spread to two to five (or more) residents, additional staff members on the test unit, or potential expansion to another unit or units. Your organization may have already started some of these next steps.
- You can follow the process you just went through to expand to other units, neighborhoods, or households. You may want to streamline some steps now that you know how the 4Ms work together for your residents.
- Reminder: Key components of this work are to Assess and Act On each of the 4Ms as a set for each resident. It is important to know how to document the team's work and change the care plans and processes based on resident needs and preferences over time.

The team may also want to consider how 4Ms documentation is going:

- Is it clearly and consistently documented in a designated location in the EHR and care plans?
- Can all team members (all relevant disciplines) access the information as needed?
- Is the information shared with CNAs through CNA care cards or whatever method CNAs use to communicate and document their practice?

Care planning and implementation of care plan content is considered an essential component of nursing home care delivery. Surveyors and regulators often check to see if care plans are being written and accurately followed by the team. Clear and consistent documentation of age-friendly care by applying the 4Ms demonstrates a nursing home's dedication to person-centered, whole-person care.

Reminder

For additional tips, charts, and examples, please review the
Age-Friendly Health Systems: Guide to Care of Older Adults in Nursing Homes.

To provide feedback on the Workbook or other resources, ask questions, share progress, or learn more about **Age-Friendly Health Systems Care of Older Adults in Nursing Homes**, please email Alice Bonner (abonner@ihi.org) or AFHS@ihi.org.

Learn more at ihi.org/AgeFriendly.