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From 4Ms to 5 domains: ensuring new CMS Age-Friendly hospital measure improves care for older adults

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Abstract

In 2024, the Centers for Medicare and Medicaid Services (CMS) added a novel Age-Friendly Hospital Inpatient Quality Reporting (IQR) Measure, composed of 10 attestation statements in 5 domains. The measure is designed to improve care for older adults through promoting care processes and structural capabilities drawn from evidence-based standards included in the 4Ms Framework (What Matters, Medication, Mentation, and Mobility) and operationalized in 3 programs: Geriatric Surgery Verification, Geriatric Emergency Department Accreditation, and the Institute for Healthcare Improvement's Age-Friendly Health System recognition. We highlight synergies and gaps between these programs and the CMS Age-Friendly IQR measure to guide hospital efforts as they prepare for their first attestation in 2026. In addition, we make recommendations to CMS to improve measure validity through better specifications that ensure meaningful impact on care for older adults and to reduce associated reporting burden. Notably, there is little overlap in the outcome measures incorporated into each program. Attending to these considerations is critical to maximize the potential of this new national quality measure to address persistent shortcomings in evidence-based care for older adults.

Key words: elder care; hospitals; Medicare; organization of care; patient-centered care.

Key points

- The CMS Age-Friendly Hospital Inpatient Quality Reporting (AF IQR) measure represents an important step toward improving the care of hospitalized older adults through establishing organizational infrastructure and care processes that comprehensively address the unique needs of this population.
- While AF IQR attestation statements closely relate to care processes as specified within existing geriatric care recognition and accreditation programs, they lack full alignment with those programs and are underspecified in key ways, raising concerns about measure validity, potentially leading to sub-optimal implementation, and creating burden for attesting hospitals.
- There are key steps that CMS can take to improve measure validity, particularly around care process frequencies, and improve synergies with geriatric care programs, particularly around outcomes, to

ensure that the new measure consistently drives improvements in quality of care for older adults.

Introduction

In 2024, the Age-Friendly Health System (AFHS) movement achieved a significant milestone with the first designated Age-Friendly hospital measure incorporated into a federal payment program. Beginning in 2025, hospitals that participate in the Centers for Medicare & Medicaid Services (CMS) pay-for-performance Hospital Inpatient Quality Reporting (IQR) program are required to attest to 10 statements within 5 domains related to care for patients aged 65 and older: (1) Eliciting Patient Healthcare Goals; (2) Responsible Medication Management; (3) Frailty Screening and Intervention; (4) Patient Vulnerability; and (5) Age-Friendly Care Leadership.¹ For those leading AFHS efforts in the inpatient setting, the Age-Friendly hospital measure has garnered new organizational engagement and will motivate all hospitals to expand focus from traditional disease/condition-centric quality measures to those that address important and interrelated domains in the health and well-being of older adults.

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The Age-Friendly (AF) IQR measure is a structural indicator “designed to assess features of a health care organization relevant to its capacity to provide good health care.”² The measure was stewarded through a collaboration between the American College of Surgeons (ACS), the American College of Emergency Physicians (ACEP), and the Institute for Healthcare Improvement (IHI).³ Each of these organizations has existing Age-Friendly programs: the Geriatric Surgery Verification (GSV) with 22 recognized sites,⁴ the Geriatric Emergency Department Accreditation (GEDA) with 575 sites,⁵ and AFHS recognition⁶ with 626 hospitals, respectively (representing 994 unique hospitals).⁷ Each program is built on evidence-based, Age-Friendly care practices, which are represented by the 4Ms Framework: a set of assessment and act on care processes that address What Matters, Medication, Mentation, and Mobility.⁶

While ~1000 hospitals have experience with 1 or more of these programs⁴⁻⁶ and therefore have at least begun to implement the 4Ms, all adult hospitals will be familiar with the concepts underlying the 4Ms as they address prevalent geriatric syndromes through the lens of patient-centered care.⁸ Yet, while the 5 AF IQR measure domains overlap with the 4Ms, they do not exactly align. Therefore, as hospitals approach their first AF IQR measure attestation for calendar year 2025 (an official certification of compliance that will occur in mid-2026), they must assess the extent to which the 2 relate—likely with a focus on whether prior 4Ms implementation meets the requirements of the AF IQR measure.

To support these efforts, our team—composed of experts in AFHS implementation and evaluation, particularly measuring adherence to 4Ms care processes—developed this narrative policy commentary to achieve 2 objectives. The first objective is to leverage our expertise in the 4Ms Framework and outcomes as operationalized by IHI AFHS, ACEP GEDA, and ACS GSV to create a crosswalk to the 5 domains of the AF IQR measure. The crosswalk can be used by hospitals and other stakeholders who are familiar with the 4Ms to understand alignment with the AF IQR measure. The second objective is to identify key areas in which the AF IQR measure domains are underspecified. Over the next year, these underspecified areas will need to be resolved by each attesting hospital, and we therefore offer guidance to help this occur more consistently. As CMS refines the AF IQR measure in the second year of reporting and beyond, we aim to identify opportunities for CMS to better align with established 4Ms care approaches. Additionally, we focus on addressing underspecified areas to improve measure validity, ensuring the measure is optimally effective in promoting improved outcomes for older adults.

Crosswalk of CMS Age-Friendly IQR measure domains to the 4Ms

The AF IQR measure applies to patients 65 years or older receiving services in the hospital, operating room, or emergency department. The measure consists of 5 domains and 10 “yes” or “no” attestation statements⁹ (Table 1). In the first year, the act of attestation (regardless of whether some, or all, of the responses are “no”) is all that is required to receive full credit. Overall, the 4Ms are represented in the AF IQR Measure. Domain 1, Eliciting Patient Healthcare Goals aligns with “What Matters”; domain 2, Responsible Medication Management aligns with “Medication”; and domain 3, Frailty Screening and Intervention aligns with “Mentation”

and “Mobility.” Malnutrition, addressed in domain 3, and Patient Vulnerability and Age Friendly Care Leadership addressed in domains 4-5 represent additional activities beyond the 4Ms.

At a detailed level, Tables 2-5 lay out the strong alignment between 4Ms care processes and 7 attestation statements. This crosswalk suggests that hospitals that are routinely delivering 4Ms care have already done much of the necessary work to positively attest to the AF IQR measure. Notably, the AF IQR measure draws on components of IHI AFHS recognition requirements,¹² ACEP GEDA capabilities,¹³ and ACS GSV Program standards.¹⁴ For example, the ACS GSV specifies how to stage What Matters care processes around major procedures (included in domain 1). ACEP GEDA specifies how to minimize mentation risks (delirium in particular) by reducing ED boarding time (included in domain 3). IHI AFHS care processes offer a more consistent structure across the 4Ms, with “assessment” and “act on” processes for each M, including specificity around screening frequencies and use of specific screening tools for Medication, Mentation, and Mobility (included in domains 2 and 3). In general, GSV and GEDA are more prescribed and targeted as well as focus more on referrals, transitions of care, and documentation processes. The final column in Tables 2-5 calls out where hospitals may need to devote particular effort to positively attest to each AF IQR statement.

The remaining AF IQR attestation statements do not directly align with the 4Ms—though many align with other elements of the 3 programs, other CMS initiatives, and Age-Friendly geriatric care beyond the 4Ms (Table 6). For example, domain 3 includes malnutrition screening and management, which are part of both GEDA and GSV. As another example, GEDA includes screenings for geriatric-specific vulnerabilities that align with domain 4. Thus, taken together, the AF IQR attestation statements include, as well as go beyond, the 4Ms and approximate, a superset of activities across IHI AFHS, ACEP GEDA, and ACS GSV.

Interestingly, the AF IQR measure, IHI AFHS, ACEP GEDA, and ACS GSV are poorly aligned on the outcomes that should be tracked for older adults (Table 7). The AF IQR measure, GSV,¹⁴ and GEDA¹⁸ all require some tracking of outcomes, while IHI AFHS only recommends it.¹⁹ However, there is little overlap between the specific outcome measures—with no measures in common across all 4 initiatives and only readmissions in common across 3 of the 4 (and only 2 of the 4 specify that the measure should be 30-day readmissions). The AF IQR requirement includes 3 outcome measures—30-day readmissions, rate of falls (also in GSV), and decubitus ulcers—and therefore, does not represent a superset or subset of outcomes from the other programs.

Hospitals without prior experience with IHI AFHS, GSV, and/or GEDA may face challenges in prioritizing and implementing AF IQR domains. Domains 1-4 require upfront, multi-disciplinary work to build knowledge and training programs, design minimally burdensome documentation workflows with EHR integration, and align with other clinical processes and roles. Domain 3 in particular requires significant work to define protocols addressing a breadth of assessment and management domains. These challenges are likely to disproportionately impact rural and safety-net hospitals—specifically those with less sophisticated EHRs and staff juggling multiple responsibilities for whom specialized trainings

Table 1. CMS Age-Friendly IQR measure's attestation domains and statements.¹⁰

Attestation domains ^a	Attestation statements: attest “yes” or “no” to each element. (Note: Affirmative attestation of all elements within a domain would be required for the hospital or health system to receive a point for that domain)
Domain 1: Eliciting Patient Healthcare Goals This domain focuses on obtaining patient's health-related goals and treatment preferences which will inform shared decision-making and goal concordant care	(A) Established protocols are in place to ensure patient goals related to healthcare (health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record. These goals are updated before major procedures and upon significant changes in clinical status
Domain 2: Responsible Medication Management This domain aims to optimize medication management through monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm	(A) Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMs should be considered for discontinuation, and/or dose adjustment as indicated
Domain 3: Frailty Screening and Intervention This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition for the purpose of early detection and intervention where appropriate	(A) Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments ideally upon admission, before major procedures, and/or upon significant changes in clinical status (B) Positive screens result in management plans including but not limited to minimizing delirium risks, encouraging early mobility, and implementing nutrition plans where appropriate. These plans should be included in discharge instructions and communicated to post-discharge facilities (C) Data are collected on the rate of falls, decubitus ulcers, and 30-day readmission for patients > 65. These data are stratified by variables of interest such as sex, payer source, age, and other factors the provider determines valuable in identifying improvement strategies for all populations (D) Protocols exist to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 6 hours of the decision to admit
Domain 4: Patient Vulnerability This domain seeks to ensure that hospitals recognize the importance of vulnerability screening of older adults and have systems in place to ensure that issues are identified and addressed as part of the care plan	(A) Older adults are screened for geriatric-specific vulnerability including isolation from community, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse to identify those who may benefit from care plan modification. The assessments are performed on admission and again prior to discharge (B) Positive screens for vulnerability (including those that identify patients at risk of social determinant of health issues and mistreatment) are addressed through intervention strategies. These strategies should include appropriate referrals and resources for patients upon discharge
Domain 5: Age-Friendly Care Leadership This domain seeks to ensure consistent quality of care for older adults through the identification of an age-friendly champion and/or interprofessional committee tasked with ensuring compliance with all components of this measure	(A) Our hospital designates a point person and/or interprofessional committee to specifically ensure age-friendly care issues are prioritized, including those within this measure. This individual or committee oversees such things as quality related to older patients, identifies opportunities to provide education to staff, and updates hospital leadership on needs related to providing age-friendly care (B) Our hospital compiles quality data related to the Age-Friendly Hospital measure. These data are stratified by variables of interest such as sex, payer source, age, and other factors the provider determines valuable in identifying improvement strategies for all populations and should be used to drive improvement cycles

^aIn August 2025, CMS released further specifications for the Age-Friendly IQR Measure, which are reflected in this Table.¹¹

in these domains are unrealistic.^{16,20} Smaller patient populations in rural settings may also make it harder to demonstrate impact or justify investing in Age-Friendly protocols.

Underspecified areas and implications for hospital attestation

Four key considerations emerge from where the 4Ms and the AF IQR attestation statements differ or are underspecified.

We assess the potential impact on measure validity to improve outcomes for older adults and offer suggestions for attesting hospitals as well as policymakers to improve validity.

Consideration 1: specifying the target population and approach to adherence measurement

The AF IQR measure has 2 features that create uncertainty about the extent to which it will impact care for all older adults

Table 2. Alignment between CMS Age-Friendly IQR measure¹ and IHI¹²/ACEP¹³/ACS¹⁴ 4Ms care processes: What Matters.^a

4Ms Framework	Recommended care process	Minimum frequency	CMS AF IQR domain	CMS AF IQR statement	Key efforts to meet IQR statement
What Matters	IHI AFHS: Assess: What Matters assessment	Once per encounter and upon significant change of condition	Domain 1: Eliciting Patient Healthcare Goals	Our hospital has protocols in place to ensure patient goals related to healthcare (ie, health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record These goals are updated before major procedures and upon significant changes in clinical status	1) Define major procedures and significant changes in clinical status, and then align frequency of assessment 2) Following assessment, process for EHR documentation of living wills, identification of healthcare proxies, and advance care planning
	IHI AFHS: Act On: Align What Matters with care plan	Unspecified			
	ACS GSV: Assess (1) overall health goals (not limited to current condition), (2) treatment goals (specific to current condition), and (3) anticipated impact of treatment on symptoms, function, and living situation. These are documented in the EHR with a verbatim quote by the patient, attestation that both surgical and non-surgical treatments have been discussed, and recommended treatment plan acknowledging how it was informed by patient goals	Twice before surgery—initial conversation with opportunity to reaffirm			
	ACS GSV: Code status, advance directives, and medical proxy must all be reviewed preoperatively by the surgeon and documented in the EHR ACS GSV: Patient must be offered the opportunity to reaffirm initial decision-making about goals of care before the operation	Goals of care must be revisited for any patients with an unexpected ICU admission and readdressed every 3 days for all ICU patients			

^aGreen columns represent the 4Ms as specified by IHI AFHS, ACEP GEDA, and ACS GSV; blue columns represent aligned AF IQR statements.

Table 3. Alignment between CMS Age-Friendly IQR measure¹ and IHI¹²/ACEP¹³/ACS¹⁴ 4Ms care processes: medication.

4Ms Framework	Recommended care process	Minimum frequency	CMS AF IQR domain	CMS AF IQR statement	Key efforts to meet IQR statement
Medication	IHI AFHS: Assess: Medication screening for high-risk medications	Once per encounter and upon significant change of condition or with a change of medication	Domain 2: Responsible Medication Management	Our hospital reviews medications for the purpose of identifying potentially inappropriate medications (PIMS) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS should be considered for discontinuation and/or dose adjustment as indicated	1) Define major procedures and significant changes in clinical status and then align frequency of assessment 2) Define list of potentially inappropriate medications
	IHI AFHS: Act On: Deprescribe, or pharmacy consult	Once per encounter			

in the hospital. First, the attestation statements are designed around the existence of processes or protocols in the hospital. Hospitals are not required to report whether these *apply to all patients over age 65 or only to certain subsets*. Further, it is possible that hospitals will interpret “receiving services in

the hospital, operating room, or emergency department” as the flexibility to only focus on a single care setting, which would dramatically limit the potential impact—particularly if they focus only on the ED for which only 1 attestation statement directly applies.

Table 4. Alignment between CMS Age-Friendly IQR measure¹ and IHI¹²/ACEP¹³/ACS¹⁴ 4Ms care processes: mentation.

4Ms Framework	Recommended care process	Minimum frequency	CMS AF IQR domain	CMS AF IQR statement	Key efforts to meet IQR statement
Mentation	IHI AFHS: Assess: Delirium screening using an approved delirium screening tool	Every 12 hours	Domain 3: Frailty Screening and Intervention	Our hospital screens patients for risks regarding mentation using validated instruments ideally upon admission, before major procedures, and/or upon significant changes in clinical status.	1. Define a major procedure and significant change in clinical status and then align screening frequencies between shift-level and upon admission, major procedure, and change in clinical status
	IHI AFHS: Act On: All 5 of the following: (1) Oral hydration; (2) Orientation; (3) Access to personal adaptive equipment; (4) Prevent sleep interruptions; (5) Avoid high risk Medications	Varies (some unspecified, some per shift)	Domain 3: Frailty Screening and Intervention	Our hospital utilizes positive screens to create management plans including but not limited to minimizing delirium risks. These plans should be included in discharge instructions and communicated to post-discharge facilities	2. Add delirium management plan to patient discharge instructions and discharge summary for post-acute facilities
	ACS GSV: Discharge paperwork must include (1) any deficits discovered on delirium risk screens along with the plan of action to address any vulnerability and (2) information regarding common geriatric syndromes, including risk factors for delirium and how to respond if it occurs after discharge				
	ACEP GEDA: Care processes to (1) minimize ED boarding for geriatric patients at high risk for harm (eg, with delirium) AND/OR (2) optimize care of geriatric patients at high risk for harm (eg, with delirium) who are boarding in ED for extended period of time after admission decision	Once per encounter	Domain 3: Frailty Screening and Intervention	Our hospital has protocols to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 8 hours of arrival and/or within 3 hours of the decision to admit	3. Generate measure of geriatric patients transferred out of the ED within 8 hours of arrival and/or within 3 hours of the decision to admit; set target goal and monitor

Second, the AF IQR attestation statements do not specify thresholds; that is, what percent of hospital encounters for older adults must demonstrate adherence to each statement to attest yes vs no? Only the GSV Program has set benchmarks for the reach of care, requiring that program standards touch 25%-49% or 50+% of the hospital's eligible surgical patients aged 75+ to achieve GSV Focused Excellence or Comprehensive Excellence, respectively. (Since finalization of the AF IQR measure, GSV has revised to age 65+.)²¹

Given that the 4Ms Framework is designed as a complementary set, it is critical that each care process is not pursued independently, and instead, the key measure is what percent of hospital encounters receives all 4 Ms or meets all attestation statements.²² Aspirationally, this should also be approached with consideration of whether care processes occurred with optimal synchrony or alignment. For example, if there are long gaps between screening and management plans in response to screening outcomes, the opportunity for improved care outcomes is substantially diminished.

In the near term, attesting organizations will define their target population within the CMS-specified parameters and determine whether their level of adherence—to individual attestation statements based on self-determined frequency specifications and

collectively across all—is aligned with the intent of the AF IQR measure. To begin, a feasible approach is to include all individuals age 65+ who spent any amount of time admitted to the hospital and, for each attestation statement in domains 1-4, construct an encounter-level measure. This would include measures of care process adherence (eg, did the encounter include malnutrition screening?), outcomes (eg, whether the patient had a fall), and demographics (eg, sex, payer source).

Over time, a more sophisticated approach to measuring care process adherence should be pursued. Critically important and perhaps unique to the IHI AFHS 4Ms measure is the need to assess encounter-level adherence to the care processes *as a set*. Reporting that X% of encounters met attestation statement 1a and Y% of encounters met attestation statement 1b (and so on) fails to capture the proportion of encounters that received comprehensive 4Ms care. Hospitals beginning with an encounter-level reporting structure will be best positioned to construct such a composite measure.

Consideration 2: specifying care process frequencies

The AF IQR attestation statements approach the question of frequency of care processes without a clear, consistent

Table 5. Alignment between CMS Age-Friendly IQR measure¹ and IHI¹²/ACEP¹³/ACS¹⁴ 4Ms care processes: mobility.

4Ms Framework	Recommended care process	Minimum frequency	CMS AF IQR domain	CMS AF IQR statement	Key efforts to meet IQR statement
Mobility	IHI AFHS: Assess: Mobility screening using an approved screening tool, or referral to physical therapy	Once per encounter and upon change of condition	Domain 3: Frailty Screening and Intervention	Our hospital screens patients for risks regarding mobility using validated instruments ideally upon admission, before major procedures, and/or upon significant changes in clinical status	1. Define major procedures and significant changes in clinical status, and then align frequency of assessment
	IHI AFHS: Act On: Ambulate 3 times a day PLUS 1 or more of the following 5 options: (1) Out of bed or leave room for meals; (2) Physical therapy; (3) Avoid restraints; (4) Remove catheters and other tethering devices; (5) Avoid high-risk medications	Varies	Domain 3: Frailty Screening and Intervention	Our hospital utilizes positive screens to create management plans including but not limited to encouraging early mobility. These plans should be included in discharge instructions and communicated to post-discharge facilities	2. Add mobility plan to patient discharge instructions and discharge summary for post-acute facilities
	ACS GSV: Discharge paperwork must include (1) any deficits discovered on mobility screens along with the plan of action to address any vulnerability and (2) information regarding common geriatric syndromes, including risk factors for falls and how to respond if it occurs after discharge				

standard. The domains use the term “ideally” along with “and/or” in several attestation statements. For example, attestation statement 3a reads, “Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments *ideally* upon admission, before major procedures, *and/or* upon significant changes in clinical status.” This suggests that the attesting organization could attest as long as it meets the minimum frequency (ie, upon admission). However, other attestation statements are more definitive, such as in the Eliciting Patient Healthcare Goals where the required frequency is “before major procedures *and* upon significant change in clinical status.” Conceptually, upon admission is most straightforward to implement, align, and track; it is equivalent to an encounter-level frequency (though it is more specific about when in the encounter the process must occur) and can be aligned with shift- or day-level frequencies that are specified for some 4Ms care processes by IHI AFHS implementation guides. GSV includes a definition for what should be considered a major procedure—“operations that are expected to need 2 or more midnights of medically necessary hospital care.”²³ They require that goals of care and geriatric vulnerability screenings be conducted prior to the operation and upon discharge. Additionally, GSV Program standards state that “goals of care must be revisited when an older adult experiences an unexpected escalation of care to the ICU and must be readdressed at least every 3 days for all ICU patients,”¹⁴ helping to inform what could be defined as a significant change in clinical status.

Collectively, this ambiguity and flexibility place a substantial burden on hospitals, requiring them to develop their own definitions for care frequency. Additionally, hospitals

face the complexity of measuring and tracking compliance with care processes at different frequencies, particularly in cases where a single encounter involves multiple procedures. Undoubtedly, hospitals will make different decisions and, since there is no gold-standard evidence on optimal frequencies, frequency specifications will likely be guided by balancing the burden of repeating an assessment or action with the likelihood that it generates new, actionable information.

Given the AF IQR measure flexibility, hospitals will need to decide in a nuanced way which procedures or clinical status changes would likely produce different assessment outcomes, which would then trigger a change in care plan. For example, following an orthopedic procedure like a hip fracture repair, conducting a mobility assessment upon admission would likely yield an inability to walk and a bed rest goal, with the mobility assessment after surgery likely offering the returned ability to stand or walk with assistance and daily mobility goals set from there. While setting a higher frequency bar for mobility assessment, pre-procedure would result in added clinician burden to administer screenings that do not generate actionable changes in care, regular screening post-procedure would generate important information about mobility progress and associated changes to mobility goals. As a second example, reviewing What Matters to a patient once during a hospitalization may generally be sufficient. However, changes in the patient’s clinical conditions or the need for additional procedures may warrant reassessment—particularly if the patient becomes unable to return to their prior place of residence.

As a starting point, it would be helpful to develop a shared list of procedure codes and operationalization of changes in

Table 6. New dimensions of CMS Age-Friendly IQR measure¹ that go beyond 4Ms care Processes.¹²⁻¹⁴

4Ms Framework	CMS AF IQR domain	CMS AF IQR statement	Potential synergies and key new actions
None associated	Domain 3: Frailty Screening and Intervention	Our hospital screens patients for risks regarding malnutrition using validated instruments ideally upon admission, before major procedures, and/or upon significant changes in clinical status	ACS GSV includes screening for malnutrition and documented management plan (eg, preoperative referral to nutrition to evaluate for nutritional supplements prior to surgery) as part of geriatric vulnerability assessments. This screening must be done preoperatively and upon discharge. ACEP GEDA care processes include a protocol for screening of nutritional status or food insecurity with appropriate follow-up actions in response to screening results. Example tools include HFIAS, MNA
	Domain 3: Frailty Screening and Intervention	Our hospital utilizes positive screens to create management plans including but not limited to implementing nutrition plans when appropriate. These plans should be included in discharge instructions and communicated to post-discharge facilities	
None associated	Domain 4: Patient Vulnerability	Older adults are screened for geriatric-specific vulnerability (including isolation from community, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse) to identify those who may benefit from care plan modification. These assessments are performed on admission and again prior to discharge	ACEP GEDA care processes include protocols for screening or assessment for social isolation and elder abuse using an established tool, with appropriate follow-up actions in response to screening results. Example social isolation screening tools include the Duke Social Support Index and the UCLA 3-Item Loneliness Scale. Example elder abuse screening tools include EM-SART, ED Senior AID, EASI, or H-S/EAST Many hospitals screen for social vulnerability ¹⁵ and there is a separate IQR structural measure (SDOH-1) that requires screening for patient needs related to housing, food, transportation, and personal safety. Therefore, hospitals may need to newly focus on screening for isolation and access to appropriate caregiving resources as well as the subsequent referral workflows
	Domain 4: Patient Vulnerability	Our hospital utilizes positive screens for vulnerability (including those that identify patients at risk of mistreatment) and addresses them through intervention strategies. These strategies should include appropriate referrals and resources for patients upon discharge	
None associated	Domain 5: Age-Friendly Care Leadership	Our hospital designates a point person and/or interprofessional committee to specifically ensure age-friendly care issues are prioritized, including those within this measure. This individual or committee oversees such things as quality related to older patients, identifies opportunities to provide education to staff, and updates hospital leadership on needs related to providing age-friendly care	ACEP GEDA (Silver Level 2, Silver and Gold Level 1) and GSV both require that there be a director who leads the program and coordinates care delivered in accordance with program standards To achieve IHI AFHS Level 2 recognition, hospitals must submit data on counts of older adults receiving 4Ms care, and these data must be stratified by race, ethnicity, and language. ⁹ To achieve ACS GSV Focused or Comprehensive Excellence (the top 2 of 3 levels of participation), program standards must reach 25%-49% (Focused Excellence) or 50+% (Comprehensive Excellence) of the hospital's eligible surgical patients aged 75+ ¹⁶
	Domain 5: Age-Friendly Care Leadership	Our hospital compiles quality data related to the Age-Friendly Hospital Measure. These data are stratified by variables of interest such as sex, payer source, age, and other factors the provider determines valuable in identifying improvement strategies for all populations and should be used to drive improvement cycles	

clinical status for which there is consensus on the value of re-assessment—either across the board or by assessment domain. Even more practically, hospitals could define changes in clinical status as those that, at a minimum, require a transfer of care (eg, to an intensive care unit) or a medication review. Similarly, a list of major procedures could be compiled across the 22 GSV sites that have had to determine which procedures are expected to require at least 2 nights in the hospital.

In the longer run, there is a need for evidence to guide the specification of standard optimal frequencies. It is likely that optimal frequencies will differ not only by the specific care process but also by a broad set of patient-level factors. As hospitals interpret and implement these frequencies differently in response to the AF IQR measure, there is an opportunity for multi-site studies to generate such evidence. Artificial intelligence tools may also be useful to predict whether an

assessment is likely to generate new, actionable information and achieve a personalized approach to screenings that avoid the tradeoffs of under- vs over-screening.

Consideration 3: improved documentation and communication of 4Ms care to support care transitions

GEDA and GSV Programs include guidance to ensure the continuity of Age-Friendly care across settings. GEDA specifies a protocol for post-discharge follow-up with the patient or caregiver to discuss discharge plans and ensure access to subsequent care.¹³ GSV requires that the discharge summary include any risk factors identified by the geriatric vulnerability assessments (including cognitive, delirium, functional, and mobility screenings) along with a plan of action to address each vulnerability. It also requires a process for bidirectional

Table 7. Outcomes metrics specified across IHI AFHS,¹² ACS GSV,¹⁴ ACEP GEDA,¹³ and CMS Age-Friendly IQR measure.¹

IHI AFHS (Recommended for inpatient setting) ^a	ACS GSV	ACEP GEDA (Silver Level 2 must track at least 3 of the below; Gold Level 1, at least 5)	CMS AF IQR Measure Our hospital collects data on the rate of falls, decubitus ulcers, and 30-day readmissions for patients >65. These data are stratified by variables of interest such as sex, payer source, and age
30-day readmissions	Unplanned readmissions Inpatient falls		30-day readmissions Inpatient falls Decubitus Ulcers
Delirium	Healthcare-acquired infections Restraint use Mortality Rates of postoperative delirium Rates of postoperative deconditioning (as defined by the institution)	Hospital admissions Repeat ED visits Extended ED stays Discharge disposition Outcomes of completed referrals Percentage of patients receiving applicable interventions (process measure) Percentage of patients receiving relevant referrals (process measure)	
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions Length of stay collaboRATE (or similar tool to measure goal concordant care)			

^aAlso recommends stratification by OMB-defined race and ethnicity categories.¹⁷

communication between post-acute care facilities and the institution to track patient outcomes.¹⁴

The AF IQR measure focuses on the need for inclusion in discharge documentation of a mobility plan and delirium management plan for all patients in the hospital setting. However, continuity is not addressed for other important areas (eg, what matters, malnutrition). Further, given that discharge documents are typically lengthy, the key is not simply a plan inclusion but ensuring that the content is clearly called out and framed in an actionable way. This may require, for example, (1) a standalone 4Ms/AF summary added as a face sheet to the discharge summary, (2) 4Ms/AF content embedded directly into the physician-written discharge summary, and/or (3) a patient-facing 4Ms/AF summary that can be shared by patients and caregivers with post-acute care providers. Rather than focus on adding new documentation requirements, these efforts could focus on improving the visibility of 4Ms/AF care information, especially through leveraging emerging technologies such as generative artificial intelligence summarization. Identifying best practices for continuity of the full spectrum of Age-Friendly care from hospitals to post-acute facilities (and ideally extending the AF IQR requirements to primary care settings) is critical and represents a key mechanism through which the AF IQR measure will have maximum impact on care outcomes for older adults.

Consideration 4. Making What Matters matter

The most challenging M to implement within the 4Ms Framework has been What Matters.²⁴ Compared with the other Ms that have well-defined clinical guidelines and procedures, What Matters does not have an existing framework or tool that fully supports the processes of eliciting, documenting, and building care plans around what matters to older adults. Most approaches to capturing What Matters focus on tools such as advanced directives and serious illness conversation guides (though IHI AFHS has been clear that end-of-life focus alone, such as presence of an advanced directive, is insufficient).²⁵ While these tools are appropriate and valuable, they can be reductive in that they often fail to capture patient priorities outside of end-of-life or in serious illness contexts, instead focusing on treatment or clinical-related topics. This prevents the inclusion of a wide range of potential health goals and priorities of older adults across different care settings and illness contexts.

The GSV Program standard represents a higher bar by requiring documentation that reflects how patient goals informed the treatment plan, improving capture of how this domain may shift decision-making for patient care.¹⁴ It would be helpful to learn best practices from the 22 GSV sites. However, the AF IQR attestation statement does not go this far, only requiring documentation and updating of goals, which could further exacerbate a reductive approach to

conceptualize and operationalize What Matters. Hospitals should look to recent work that seeks to guide how frontline care teams interpret and adjust care based on What Matters,^{25,26} including toolkits from Patient Priorities Care that were developed specifically to support the 4Ms.²⁷ Yet there remains substantial latitude and therefore a critical opportunity for hospitals to share emerging best practices.

AF IQR domains and overlap with measures beyond those designated as age-friendly

While alignment between the AF IQR measure and prior AF efforts was expected, perhaps less expected was the similarity to other CMS IQR measures. Notably, CMS IQR Social Determinants of Health (SDOH) measures require hospitals to ask about 5 health-related social needs: (1) housing instability, (2) food insecurity, (3) transportation needs, (4) utility difficulties, and (5) interpersonal safety (presence of physical or verbal abuse).¹¹ Hospitals already report screening levels for these items and the proportion of positive screens to CMS. Food insecurity relates to domain 3 screening for malnutrition while interpersonal safety screening relates to domain 4 screening for geriatric-specific vulnerability such as isolation from community, elder abuse, and economic insecurity.

This raises questions about whether processes designed to meet the SDOH IQR measures should also count as meeting the AF IQR attestation statements. The AF IQR measure is more specific to older patients (ie, elder abuse vs “interpersonal safety”), and perhaps in future versions, these can be aligned. Although important, malnutrition, isolation from community, elder abuse, and economic insecurity are not explicitly part of the 4Ms Framework and therefore likely come with additional work to package with existing Age-Friendly implementation efforts (though some build off GSV and GEDA requirements).

There is a broader question of whether the AF IQR measure may improve or exacerbate disparities in care delivery. Prior work on 4Ms adherence has shown mixed results—with a study in the ambulatory setting finding that gender, verbal English proficiency, and MyChart activation were positively associated with adherence to some 4Ms care processes,¹⁵ and an inpatient study finding no difference in 4Ms adherence by key patient demographics (eg, verbal English proficiency, race/ethnicity).²⁸ Our assessment is that the AF IQR measure has the potential to reduce disparities by specifying care processes that should be delivered to all older adults as well as promoting data collection on adherence stratified by demographic variables. However, the AF IQR measure may result in disparities if hospitals with fewer resources or more complex patient populations are less able to implement these processes and then financially penalized in the future (as has occurred with other CMS structural measures).²⁹

A second area of potential overlap is with the CMS Patient Safety Structural Measure (PSSM), which focuses on healthcare organizations’ practices and strategies to build and strengthen safety culture.¹¹ Attestation statements include the following:

1. Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation.
2. Our hospital has a patient safety metrics dashboard and uses external benchmarks (such as CMS Star Ratings or other national databases) to monitor performance and inform improvement activities on safety events (such as medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare-associated infections).
3. Our hospital safety goals include the use of metrics to identify and address disparities in safety outcomes based on the patient characteristics determined by the hospital to be most important to healthcare outcomes for the specific populations served.

These statements relate to AF IQR domains 3 and 5, with the most direct relationships to attestation statements 3c (collecting data specifically on falls, decubitus ulcers, and 30-day readmissions) and 5b related to collecting broader quality data related to the AFHS Measure that can be stratified by demographic variables and is used to drive improvement cycles. While the PSSM does not specify frontline care practices that can be undertaken to improve safety, there is potential for the 4Ms care processes to be aligned with the attestation statements to improve medication errors and falls. One possible alignment is to update PSSM statements to include more specific safety considerations for older adults (eg, falls resulting from delirium).

Looking ahead: priority areas for CMS to maximize impact of the AF IQR measure

CMS decisions about how to refine the AF IQR measure over time will have profound downstream impact on compliance requirements, care delivery, and associated outcomes for older adults. Our considerations point to clear priorities for near-term actions to improve measure validity.

First, more precisely defining attestation statements would reduce the burden on hospitals to interpret each statement. It would have important secondary benefits in terms of bringing greater standardization to AF inpatient care, which currently reflects substantial heterogeneity given that IHI AFHS, GEDA, and GSV allow significant flexibility and customization. Specifically, CMS should facilitate a collaborative effort to define major procedures and changes in clinical status based on commonly available structured data, with input from those with geriatrics expertise. Additionally, CMS should clarify areas of overlap between the AF IQR measure and other IQR measures—in particular the SDOH and PSSM measures—to reduce any redundancies in care delivery and reporting. Nonetheless, it is also important to recognize that the AF IQR measure goes beyond the 4Ms in non-trivial ways and that, even with more specificity, hospitals will still experience burden associated with attestation. As the AF IQR measure evolves from yes/no attestation to reporting levels of adherence, CMS should explore billing codes to more directly reimburse Age-Friendly care, further reinforcing the expansion in focus beyond condition/disease-focused care.

Second, CMS should consider building stronger accountability for effective care transitions by incorporating outcomes beyond 30-day readmissions that focus on older adults’ unique needs. For example, assessing falls or onset of delirium in the post-acute care setting could generate a more nuanced understanding of the impact of Age-Friendly care. Relatedly, domain 1 has the potential to markedly improve how we

define, capture, and measure What Matters. As a notoriously challenging M to operationalize given the wide variation in how it is interpreted and implemented, CMS could support collaborative work that includes patients, families, clinicians, and hospital systems to achieve a more standardized approach to centering AF work on What Matters.

Lastly, prior work points to significant effort required to evolve from specification of 4Ms care processes to reliable practice of those processes for every encounter.²² Thus, over time, CMS should move to encounter-level thresholds for full adherence. Yet doing so poses a key challenge: setting appropriate thresholds. If thresholds are too low, they may not drive meaningful improvements in care for older adults. If they are too high, they become unattainable targets. To inform threshold setting using real-world data, CMS could work with the 300 US hospitals that have level 2 IHI AFHS recognition as this necessitates measurement of 4Ms care adherence,³⁰ ideally capturing individual process adherence as well as encounter-level composite measures. Another option is to build on the CMS regulatory authority to validate IQR data and collect current-state, encounter-level adherence measures from selected hospitals.³¹

Ultimately, CMS along with the broader AFHS community will need such data to build evidence for how Age-Friendly care practices—whether it be the 4Ms, the 5 AF IQR domains, or other frameworks—improve outcomes for older adults. Gaining consensus on the key outcomes—particularly given the heterogeneity in current outcomes across AF IQR, IHI AFHS, ACS GSV, and ACEP GEDA—is a foundational step. It is this evidence that will be most critical in driving toward a valid AF IQR measure that is minimally burdensome while maximizing gains for older adults.

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Supplementary material

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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