Age Friendly Hospital Measure

Performance Measure Name: Age Friendly Hospital Measure

Description: This programmatic measure assesses hospital commitment to improving care for patients ≥ 65 years of age receiving services in the hospital, operating room (OR), or emergency department (ED). The clinical measure consists of 5 domains that each address an essential aspect of clinical care for the older patient. The number of eligible domains (5) serves as the denominator. The verifiable attestation is met when all domain components are met for the majority of patients > 65. The numerator is the number of domains for which a hospital meets all attestations.

If finalized, hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program would need to complete the attestation during the Centers for Medicare & Medicaid Services (CMS)-specified time period. The five domains for hospital attestation and key elements for each domain include:

- **Domain 1: Eliciting Patient Healthcare Goals:**
  This domain focuses on obtaining patients' health-related goals and treatment preferences which will inform shared decision making and goal-concordant care. Please attest that your hospital engages in the following:
    A. Our hospital has protocols in place to ensure patient goals related to healthcare (i.e., health goals, treatment goals, living wills, identification of health care 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. Please attest that your hospital engages in the following.
    A. 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.

- **Domain 3: Frailty Screening and Intervention (i.e. Mobility, Mentation, and Malnutrition):**
  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. Please attest that your hospital engages in the following:

A. Our hospital screens patients 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. Our hospital utilizes positive screens to create 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. Our hospital collects data on the rate of falls, decubitus ulcers, and 30-day readmission for patients > 65. These data are stratified by sex/gender, race, age, and ethnicity.
D. 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.

- **Domain 4: Social Vulnerability (social isolation, economic insecurity, ageism, limited access to healthcare, caregiver stress, elder abuse):**
  This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan. Please attest that your hospital engages in the following:
  A. Our hospital screens older adults for geriatric-specific social vulnerability including social isolation, 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. Our hospital utilizes positive screens for social 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.

- **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. Please attest that your hospital engages in the following:
  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 sex/gender, race, age, and ethnicity, and should be used to drive improvement cycles.

Clarifying Information: The Age Friendly Hospital Measure includes five attestation-based questions, each representing a separate domain of commitment. For a hospital to affirmatively attest to a domain, and receive credit for that domain, the hospital will evaluate and determine whether it engages in each of the elements that comprise the domain. Hospitals would receive one point for each domain to which they attest "yes," stating they are meeting the required competencies; a hospital's score can be a total of zero to five points (one per domain). For each domain, there are between one and four associated yes/no sub-questions for related structures or activities within the hospital. Hospitals would only receive a point for each domain if they attest "yes" to all related sub-questions. There is no "partial credit" for sub-questions. For example, in Domain 3, hospitals must attest "yes" to sub-questions A-D in order to earn the point for that domain. If hospitals participate or complete qualifying activities at any time within the reporting year, they may attest "yes" for that domain.

Additional Resources: This measure is supported by evidence and guidance from the following:

- The American College of Surgeons' (ACS) Geriatric Surgery Verification (GSV) Program includes standards that closely align with the Domains of the Age Friendly Hospital Measure.[1]
- The American College of Emergency Physicians (ACEP) created the Geriatric Emergency Department Accreditation (GEDA), which highlights the activities that should be completed to ensure geriatric patient success during time in the Emergency Department. ACEP's GEDA website offers resources and examples of care processes to improve emergency care for older adults. [2]
- The Institute of Healthcare Improvement (IHI) developed the Age-Friendly Hospital System Initiative to help hospitals meet the challenges they face in caring for older adults head on.[3]
- The John A Hartford Foundation published an article highlighting the need for Geriatric Measures in CMS Quality Programs.[4]
- The ACS published an article that defined programmatic quality measurement and its intent to increase patient-centeredness across the episode continuum by creating better alignment of resource and conduct, care and measurement, and patient, clinician, and health system perspectives.[5]

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[1] Optimal Resources for Geriatric Surgery.
[2] Geriatric Emergency Department Accreditation Program.
[3] Age Friendly Health Systems.
[4] Snyder RE, Fulmer T. The Need for Geriatrics Measures. *Health Affairs.* April 14, 2023. Accessed December 1, 2023. https://www.healthaffairs.org/content/forefront/need-geriatrics-measures.
[5] Peters X, Sage J, Collins C, Opelka F, Ko C. Programmatic quality measures: a new model to promote surgical quality. *Health Affairs Scholar*. 2024;2(1):1-3.

- A study published in the Journal of the American College of Surgeons (JACS) outlines the development and implementation of the ACS Geriatric Surgery Quality Improvement Initiative Pilot, showing that the standards within the program can be feasibly reported, and helps hospitals to identify challenges and best practices associated with caring for older adults.[6]
- A study published in the Journal of the American Geriatrics Society describes how the clinical standards within the ACS GSV program reduced length of stay in older adults undergoing inpatient operations.[7]
- A study published in the Annals of Surgery identified that the implementation of a Geriatric Surgery Pathway improved outcomes in diverse geriatric surgery patients.[8]
- A study published in the Annals of Surgery identified that implementation of the ACS GSV program led to a significantly lower total mean cost of health care services during hospitalization following an inpatient surgical procedure for older adults.[9]
- An article published in the Journal of Aging and Health discusses the 4Ms – What Matters, Medication, Mentation, Mobility – and their importance in the care of older adults. The article states that one of the benefits of the 4M system is its unified approach to care, rather than systems that addressed problems in parallel.[10]
- The Joint Commission Journal on Quality and Patient Safety published a paper that calls for improving care by adopting the Age-Friendly Health Systems 4Ms framework.[11]
- An article published in the Journal of American Geriatrics Society highlights the benefits of both age-friendly and learning health systems and encourages stakeholders to combine aspects of both systems to increase their potential.[12]
- A study published in the Journal of American Geriatrics Society described how IHI's recommended 4Ms care practices can be translated and implemented into EHR-based, encounter-level adherence measures.[13]

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[6] Ma M, Peters X, Zhang LM, et al. Multisite Implementation of an American College of Surgeons Geriatric Surgery Quality Improvement Initiative. *J Am Coll Surg*. 2023; 237(2):171-181.

[7] Jones TS, Jones EL, Richardson V, et al. Preliminary data demonstrate the Geriatric Surgery Verification program reduces postoperative length of stay. *J Am Geriatr Soc*. 2021; 69:1993-1999.

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[9] Ehrlich AL, Owodunni OP, Mostales JC, et al. Implementation of a Multispecialty Geriatric Surgery Pathway Reduces Inpatient Cost for Frail Patients. *Ann Surg*. 2023;278(4):e726-e73

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[11] Mate K, Pelton L. The Urgent Need for the Age-Friendly Health Systems Movement. *Jt Comm J Qual Saf*. 2024; 10:S1553-7250(24)99954-0.

[12] Prusaczyk B, Burke RE. Age-friendly learning health systems: Opportunities for model synergy and care improvement. *J Am Geriatr Soc*. 2022;70(8):2458-2461. doi: 10.1111/jgs.17901. Epub 2022 Jun 2. PMID: 35652488; PMCID: PMC9378562.

[13] Thombley RL., Rogers SE, Adler-Milstein J. Developing electronic health record-based measures of the 4Ms to support implementation and evidence generation for Age-Friendly Health Systems. *J Am Geriatr Soc*. 2024;72(3):882-891.

- A study published in JAMA Internal Medicine found that older patients who spent the night in the ED had a higher in-hospital mortality rate and increased risk of adverse events compared with patients admitted before midnight.[14]
- A study published in Health Services Management Research found that prolonged wait for transfer to the hospital floor (i.e. boarding in the ED) was associated with increased risk of delirium.[15]
- A study published in the Canadian Journal of Emergency Medicine determined that the odds of a prolonged wait in the ED significantly increased for older patients and a prolonged wait time in the ED was linked to a greater inpatient length of stay.[16]
- A study published in the American Journal of Emergency Medicine found that ED boarding, among other measures of ED crowding, are associated with risk-adjusted measures of hospital spending, such as Medicare Spending per Beneficiary.[17]
- An article published in the Journal of American Geriatrics Society discusses the ways in which the 4Ms framework and other tools can prevent and manage delirium and provides further actions that should be taken to optimize care for older adults.[18]
- A study in the British Medical Journal found that delirium was a strong risk factor for death and incident dementia among older adults in hospitals.[19]

[14] Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA Intern Med*. 2023;183(12):1378-1385.

[15] Moura Junior V, Westover MB, Li F, et al. Hospital complications among older adults: Better processes could reduce the risk of delirium. *Health Serv Manage Res*. 2022;35(3):154-163. doi: 10.1177/09514848211028707. Epub 2021 Jul 11. PMID: 34247525; PMCID: PMC8748518.

[16] Salehi L, Phalpher P, Valani R, et al. Emergency department boarding: a descriptive analysis and measurement of impact on outcomes. *CJEM*. 2018;20(6):929-937. doi: 10.1017/cem.2018.18. Epub 2018 Apr 5. PMID: 29619913.

[17] Baloescu C, Kinsman J, Ravi S, etc. The cost of waiting: Association of ED boarding with hospitalization costs. *Am J Emerg Med*. 2021;40:169-172. doi: 10.1016/j.ajem.2020.10.058. Epub 2020 Nov 13. PMID: 33272871.

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