



Advancing Age-Friendly Care through the CMS IQR Age-Friendly Hospital Measure

*Insights and Recommended Strategies for Measure Evaluation
from Quality Measure Experts*

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Abstract

The CMS Age-Friendly Hospital Measure, newly incorporated into the Inpatient Quality Reporting (IQR) Program, represents an important step in driving adoption of evidence-based Age-Friendly care through federal hospital quality measurement. This report presents insights from an expert panel convened to assess the measure’s potential to drive meaningful improvement in hospital care for older adults. Panelists supported the measure’s alignment with geriatric evidence-based practices and its potential to improve care processes for older patients. However, they also raised questions related to measurement validity, reliability, burden, and equity. Using the panel’s guidance, we propose a multi-phase evaluation agenda for researchers to assess hospital implementation, attestation patterns, and associations with hospital characteristics and patient outcomes. This agenda aims to inform measure refinement, promote equitable implementation, and support hospitals in delivering more effective, person-centered care for older adults. As CMS considers transitioning from attestation to accountability, robust evaluation will be critical to maximizing the impact of this foundational measure.

Background and Context

Measure Structure & Content

The Centers for Medicare & Medicaid Services (CMS) Inpatient Quality Reporting (IQR) Age-Friendly Hospital Measure is an attestation-based, structural measure that evaluates hospitals’ capacity, protocols, and processes to deliver Age-Friendly care for adults aged 65 and older. In 2026, all acute care hospitals in the United States – over 3,000 hospitals paid under the Inpatient Prospective Payment System – that fail to attest to the status of protocols across five core domains during calendar year 2025 (see Table 1) will receive a financial penalty.¹ Compared to traditional condition-centric quality metrics in the IQR Program, the Age-Friendly Hospital Measure is a holistic patient-centered assessment of older adult care. The measure also represents a major milestone for the Age-Friendly Health Systems (AFHS) movement and its 4Ms Framework for Age-Friendly care (What Matters, Medication, Mentation Mobility), as it is the first quality measure incorporated into a federal payment program that focuses specifically on the needs of older adults.

Table 1: Age-Friendly Hospital Measure Attestation Domains and Statements²

Attestation Domains	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 patients’ health-related goals and treatment preferences which will inform shared decision making and goal-concordant care.	(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.

(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

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) 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 variables of interest such as: such as sex, payer source, age, and other factors the provider determines valuable in identifying improvement strategies for all populations.
- (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: Patient Vulnerability^a (Community isolation, economic insecurity, ageism, limited access to healthcare, caregiver stress, elder abuse)

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) Our hospital screens older adults for geriatric-specific vulnerability including isolation from the 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) 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.

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 such as: sex, payer 3 source, age, and other factors the provider determines valuable in identifying improvement strategies for all populations and should be used to drive improvement cycles.

CMS IQR Program

The CMS IQR Program is a pay-for-reporting initiative that incentivizes acute care hospitals to submit timely data for all required measures to remain in compliance. Failure to meet these requirements results in a 25% reduction in the hospital's Annual Market Basket Update, equal to

^a Domain 4 was originally titled "Social Vulnerability," but has since been renamed "Patient Vulnerability" by CMS.

approximately \$258,000 for the average hospital.^b The IQR Program includes a mix of structural, process, and outcome measures. CMS regularly updates the measure set through an annual rulemaking process.

In the FY 2025 proposed rule, CMS proposed seven new measures, including the Age-Friendly Hospital Measure. Other new measures include the Patient Safety Structural Measure, Hospital Harm (Falls with Injury and Postoperative Respiratory Failure electronic clinical quality measures (eCQMs)), two infection-related eCQMs (CAUTI and CLABSI) stratified for oncology units, and a Thirty-Day Risk-Standardized Death Rate among Surgical Inpatients with Serious Complications.¹ These additions reflect CMS's growing focus on foundational infrastructure and safety. Structural measures in particular assess whether hospitals have essential policies, protocols, and organizational practices in place to support high-quality care. Structural measures typically have a yes / no answer set and are measured at a hospital or unit level, rather than the patient level.^{1,4,5}

Hospitals and health systems participating in the CMS IQR Program must submit data on an annual basis. For calendar year 2025 reporting period (January 1 – December 31, 2025), data must be submitted during the designated submission window of April 1 – May 15, 2026. These submissions will inform FY 2027 payment determinations.¹ Attestation data for structural measures will be published online through the Hospital Compare platform and the CMS Provider Data Catalog following the submission window.⁶ While the exact publication timing is unknown, CMS has stated that the Patient Safety Structural Measure data will be available online in Fall 2026.¹ We anticipate a similar timeline for the Age-Friendly Hospital Measure data.

Specific to the Age-Friendly Hospital Measure, hospitals are required to report a yes or no attestation to each of the ten elements within the five domains across all facilities covered under their CMS Certification Number. Regardless of their response, attestation to each of the 10 elements meets the pay-for reporting requirements. To assess performance – currently unrelated to payment – the measure will be scored out of a total of five possible points (one point for each domain). To earn a point, hospitals must attest positively to all statements within that domain. The CY 2025 submission is intended to establish a national baseline and inform how CMS ramps up requirements over time.¹

History of Measure Development and Relationship to Other Age-Friendly Programs

The Age-Friendly Hospital Measure was developed in response to a growing recognition that the principles of Age-Friendly care should be reliably delivered to all hospitalized older adults,

^b The IQR penalty reduces a hospital's Annual Market Basket Update by 25%. For FY 2025, CMS finalized an Annual Market Basket Update of 2.9% for hospitals that are meaningful EHR users.¹ Thus, the penalty equals 0.725% of a hospital's Medicare IPPS payments. As of FY22, there were approximately 3,100 IPPS hospitals and total IPPS spending of approximately \$110 billion.³ Thus, average Medicare IPPS revenue per hospital is estimated at approximately \$35.5 million annually. A 0.725% penalty would reduce payments by approximately \$258,000 for an average hospital. This is likely an underestimate given that IPPS spending has increased over time.

regardless of their reason for admission.⁷ Recognizing this need, stakeholders with existing Age-Friendly recognition or accreditation programs, including the American College of Surgeons (ACS), the Institute for Healthcare Improvement (IHI), and the American College of Emergency Physicians (ACEP), led a combined effort to design a hospital-wide quality measure.⁸ Specifically, ACS leads the Geriatric Survey Verification (GSV) program, with 22 recognized sites;⁹ ACEP leads the Geriatric Emergency Department Accreditation (GEDA) program, which includes 575 sites;¹⁰ and IHI leads the Age-Friendly Health Systems initiative, which recognizes 626 hospitals.¹¹ This represents 994 unique hospitals with recognition for implementing Age-Friendly care as of 6/25/2025.¹² While not an accreditation or recognition program, Nurses Improving Care for Healthsystem Elders (NICHE) is another Age-Friendly effort that provides evidence-based training, resources, and implementation support to organizations seeking to strengthen or implement Age-Friendly care.¹³ The Age-Friendly Hospital Measure draws heavily from the measurement concepts that were developed in these initiatives. This includes substantial overlap with the GSV program's domains and GEDA domains and conceptual alignment with much of the 4Ms Framework (What Matters, Medication, Mentation, and Mobility) and the NICHE model. Despite hospitals' significant engagement with Age-Friendly initiatives, around 2,000 of the approximately 3,000 acute care hospitals have no documented experience with national-scale Age-Friendly programs and will likely need to undertake new work to determine their first round of attestation responses. In the longer term, hospitals will need to engage in the harder work of implementing the broad set of Age-Friendly requirements specified by the measure.

Project Goals and Approach

As the first Age-Friendly measure in a federal payment program, it is critical to evaluate multiple aspects of the measure and its ability to drive improvements in care for older adults across hospitals. We therefore sought to identify the most critical dimensions of the measure to evaluate in anticipation of the first wave of attestation data becoming available. The key questions were: 1) whether the measure, as specified, was likely to encourage meaningful improvements in Age-Friendly care; 2) how the measure could evolve within CMS' IQR structure to have greater impact; 3) critical research areas to inform the early impact of the measure. To answer these questions, we sought to learn from hospitals' early experiences with the measure and while also drawing on broader expert opinion informed from CMS' history of quality improvement efforts.

To support these goals, we convened a national expert panel. Expert input was vital to ensure that our evaluation approach reflects the best available knowledge in quality measurement, hospital performance, health services research, and Age-Friendly care. The expert panel included:

- [Julia Adler-Milstein, PhD \(UCSF\)](#) – Co-chair
- [Andrew Ryan, PhD \(Brown University\)](#) – Co-chair
- [Cheryl Damberg, PhD, MPH \(RAND\)](#)

- [Mark Friedberg, MD, MPP \(Blue Shield MA & Brigham and Women’s Hospital\)](#)
- [David Grabowski, PhD \(Harvard Medical School\)](#)
- [Karen Joynt Maddox \(Washington University – St Louis\)](#)
- [Vince Mor, PhD \(Brown\)](#)
- [Rachel Werner, MD, PhD \(University of Pennsylvania\)](#)

Between June and August 2025, we conducted three virtual sessions with the expert panel. These sessions featured in-depth discussions of the strengths and questions about the measure and the evaluations that would best inform refinements of the measure. Specifically, discussion was structured around the questions in Table 2.

Table 2: Expert Panel Discussion Topics

Measure Properties	Adoption	Impact
<ul style="list-style-type: none"> • What parts of the measure do you like? • What parts of the measure are most concerning? • <u>Validity</u>: Are measure elements truly capturing important components of AF care? • <u>Scoring</u>: Is attestation a meaningful way to capture hospital performance on this measure? Is all or nothing scoring appropriate? • <u>Reliability</u>: Would we expect different observers within a hospital to record the same responses? • <u>Burden</u>: To what extent are measure elements irrelevant or redundant with other CMS measures? How much effort does it take to collect this data? • How should the measure evolve over time? 	<ul style="list-style-type: none"> • Do you expect that health systems will be able to meaningfully attest to these care goals? • Do you expect that hospitals within the same health system would attest consistently? • Do you expect there to be synergies with other IQR measures (i.e., If a hospital is a high performer on other IQR measures, are they more likely to meet AF domains)? 	<ul style="list-style-type: none"> • Can you point to the creation of any measures that meaningfully changed practice? • Over the next 5 years: <ul style="list-style-type: none"> ○ What is the best-case scenario with respect to how AF measure could impact hospital quality? ○ What is the most likely scenario with respect to how AF measure could impact hospital quality? • What are the main reasons the AF measure may fail to positively impact hospital quality? • Are there synergistic impacts on hospital quality between performance on the AF measure and other IQR measures?

While some discussion focused on the issues related to the initial year of attestation, most of the discussion assumed that hospitals will be working towards positive attestation across all elements. We synthesized the panel’s input and described the key insights in this report. Panelists were then given the opportunity to review the report and suggest revisions.

The following two sections are organized around the dimensions of measure assessment shown in Table 3.

Table 3: Measure Evaluation Domains and Definitions

Measure Evaluation Domain	Definition
Validity: measure level	Does the broad measure capture the latent construct (i.e., the underlying idea) of “age-friendliness”?
Validity: domain level	Does the items included in each measure domain capture the latent construct of the domain?
Validity: item level	Does positive attestation to each item reflect the existence of the underlying care process or structure? In other words, by attesting to the item, does it mean that the hospital is actually doing it?
Reliability	Is the measure capturing a high degree of “signal” (e.g. true performance) relative to noise? Over a short time period – would responses to attestation statements stay consistent if captured repeatedly? Across roles – if you asked different people within a hospital, would they respond in the same way to the attestation statements?
Burden	How much work will be required to report on the measure and improve performance in response to the measure?
Equity	Does the reporting and quality improvement related to the measure disproportionately help or harm hospitals caring for patients that differ systematically on socioeconomic characteristics?
Effectiveness	Will the measure drive improvement in outcomes for older adults?

Key Strengths of the Age-Friendly Hospital Measure

Validity: Measure Level. Panelists were supportive of the measure overall and thought that it would drive hospital engagement with Age-Friendly care in terms of prioritization and structural investment. Panelists noted that hospital care is often insufficiently focused on the unique clinical and social needs of older adults and their family caregivers. The measure therefore has the potential not only to elevate Age-Friendly care from a voluntary initiative to a core institutional priority but has the potential to spotlight and address longstanding gaps in care quality and experience for this population. One expert said, “Elevating things to the level of awareness of hospital administrators and wanting to be seen as an Age-Friendly hospital is a actually an important goal in and of itself...Let’s get everyone on board, let’s get people wanting to sign up to be an Age-Friendly hospital, and let’s make it so they can start down this pathway.”

Validity: Domain Level. Panelists also viewed the measure as having strong domain level validity, grounded in core elements of evidence-based care for older adults. Domains 2 through 4, which address medication management, frailty screening and intervention, and patient vulnerability, were described as highly relevant and reflective of best practices in geriatric care. Panelists emphasized that these domains support key outcomes such as safety, functional status, and continuity of care. In addition, Domain 5, which focuses on Age-Friendly leadership, was widely seen as critical for fostering system-level accountability and driving organizational change. Panelists agreed that strong leadership engagement is essential for ensuring institutional alignment and long-term sustainability of Age-Friendly care.

Validity: Item Level. In addition, panelists highlighted the measure’s alignment with existing best practices. Some of the processes captured by the measure, such as medication reconciliation, documentation of advance directives, and planning for discharge, are already standard practices

in many institutions. The other processes included in the measure – notably minimizing sleep disruption, ensuring effective communication of complex clinical situations, and coordinating care across hospitals and community-based services – were considered to be less widely adopted but high-value areas aligned with Age-Friendly practice. Lastly, panelists pointed to the measure’s potential for positive spillover effects beyond the older adult population. Although the measure is explicitly focused on those aged 65+, its core domains, such as goal communication and risk screening, reflect high-quality practices applicable to a wide range of patients.

Burden. Panelists also noted that the measure’s overlap with existing standards and quality improvement activities could help minimize reporting burden. Because many of the required processes are already routine in hospitals, institutions could map measure requirements onto existing workflows rather than developing new processes and systems. As one expert observed, “It’s good, because you’re not asking hospitals to come up with a whole new set of things to add on. You’re basically saying, ‘Take an Age-Friendly spin or focus on some of these processes that you’re already doing.’”

Key Areas of Concern with Age-Friendly Hospital Measure

Validity: Measure Level. Experts expressed several concerns about measure-level validity. First, they identified important dimensions of Age-Friendly care missing from the measure related to communication with the patient and their family caregivers. They noted that nothing in the measure ensures that the patient and their caregivers understand the plan for their care, its current status (specifically across the different members of the care team), and what to expect next. Second, experts noted that while a hospital could positively attest to, and have in place, each of the individual items, they could be delivered in a fragmented and uncoordinated way, which would not represent Age-Friendly care. That is, the structure of the measure does not drive how the domains work together in practice to achieve Age-Friendly care. During a hospitalization, this could compromise the ability of each domain to holistically improve care through greater coordination (e.g., a medication review in sync with mentation assessments).

Validity: Item Level. While the measure includes items that emphasize sharing of information during hospital discharge, experts felt it may not be sufficient to ensure continuity of Age-Friendly care across settings. One expert said, “[Discharge planning] is sort of buried in 3B but it’s a really, really crucial thing. For this [the Age-Friendly Hospital Measure] to evolve into something that really drives change, it [discharge planning] eventually needs to be better specified.”

Reliability. Panelists were concerned that the elements comprising the measure were not precisely specified, such that yes/no attestation may not reliably represent the targeted care processes and infrastructure. As a result, there were concerns about both reliability over time – whether responses to attestation statements remain consistent if captured repeatedly; and reliability across roles – whether different people within the same hospital would respond in the

same way to the statements. They pointed to phrases in the attestation statements such as “significant changes in clinical status,” which are subjective and lack specificity.

At the same time, panelists recognized that this vagueness may reduce burden as more precise definitions or specific performance thresholds (e.g. more than 75% of patients’ medications are reviewed for potential interactions) require more data collection and result in greater burden. This raised a fundamental trade-off between reliability and burden. CMS recently released an attestation guide that provides additional information and examples to support hospitals in determining if they meet the attestation criteria, which helps to address both sides of this tradeoff.¹⁴

Burden. Beyond the burden related to data collection, panelists pointed out the variable implementation effort across measure domains. Notably, Domain 3 was seen as a heavy lift – with many components as well as components that may be new to hospitals. Screening for frailty, cognitive impairment, or mobility limitations, especially in settings like emergency departments, presents practical and operational challenges and may require the development of additional workflows. This uneven effort across domains not only complicates implementation but may also influence hospitals’ overall performance and perceptions of feasibility and burden.

Equity. Panelists expressed concern that measure-associated burden may unintentionally disadvantage hospitals with limited resources, such as rural, safety-net, or underfunded institutions, especially for domains requiring new workflows or specialized staff. One expert said, “With any new measure it’s important to think about whether this is going to exacerbate existing disparities across hospitals...we are always concerned about how measures may disadvantage hospitals that don’t have resources to be able to fully comply with either the measurement or the implementation.” This “reverse Robin Hood effect” has occurred in other CMS’ pay-for-performance programs.^{15,16} Without targeted supports or allowances for resource variation, the measure could exacerbate disparities in care for medically or otherwise vulnerable older adults.

Effectiveness. Panelists noted overall challenges with the ability of structural measures to drive effectiveness because attestation statements are often narrow in scope and do not capture how comprehensively or consistently these structures or processes are implemented. Because of this, the link between structure and patient outcomes is indirect: structures enable, but do not guarantee, effective processes, and processes must be carried out reliably to produce outcome improvements. As a result, while structural measures are valuable for setting minimum standards and encouraging adoption, they are unlikely to drive measurable improvements in outcomes. Panelists suggested that the measure should evolve into a process measure over time as it matures within the IQR program. They also emphasized the importance of evaluation research to test ensuring that the measure ultimately delivers meaningful improvements in outcomes for older adults.

Prioritized Evaluation Approaches

Panelists suggested a set of near-term (could be undertaken in the next 12-18 months, most of which use initial attestation data) and long-term (particularly once national-scale claims-based outcomes data would be available) studies to evaluate their areas of potential concern and guide improvements to the measure. These studies are summarized in Table 4.

Near-Term Evaluations

To understand how hospitals are interpreting and operationalizing the Age-Friendly Hospital Measure, particularly the areas that lack specificity, panelists recommended an initial mixed-methods evaluation. The first component could be undertaken immediately and would involve interviews with a random sample of staff from 20–25 hospitals. Sampling would be stratified to include hospitals that have participated in Age-Friendly initiatives and those that have not. This study aims to generate a broad, representative understanding of how hospitals are approaching each dimension of the measure in areas such as: (1) interpretation of each attestation element and how they define a “yes” response; (2) who within the organization is responsible for work associated with the attestation (e.g., clinical leaders, quality staff, or administrative personnel); (3) resources they have used to support attestation and related burden; (4) new implementation work (if any) to achieve positive attestation (i.e., did they implement any new processes or structures even though it was not required).

Answers to these questions would address panelist concerns about measure validity by assessing how hospitals interpret and apply the attestation criteria and assessing variability in responses across roles within the hospital. The study would also assess measure burden by identifying resources required and which domains are most challenging or align poorly with existing workflows. Potential impacts on equity could be assessed by including diverse hospitals to identify resource-related barriers and disparities in adoption. This foundational assessment would help identify priority areas for CMS or other organizations working to support attestation (e.g., IHI, Vizient). It would also bring important context to analyses of initial attestation data (see below).

The second component would assess the relationship between the patterns and hospital characteristics, such as size, geographic location (urban, suburban, rural), and patient sociodemographic characteristics. Again, we would test several hypotheses generated by the experts about the types of hospitals most likely to achieve higher levels of positive attestation. (1) Suburban, affluent, medium-sized hospitals, which often demonstrate strong performance across a range of quality indicators (burden; measure-level validity); (2) hospitals with affiliated primary care groups, which may have better coordination, more robust goal-setting processes, and enhanced continuity of care (domain-level validity); (3) hospitals with prior experience in Age-Friendly programs, including participation in IHI’s AFHS recognition program, ACEP’s GEDA program, or the ACS’s GSV program (measure-level validity). This may also extend to hospitals with ACE units, geriatric trauma surgery programs, geriatric consult teams, or palliative

care services. To support this hypothesis-driven analysis, we would link attestation data to AHA Annual Survey data as well as Age-Friendly program participation/recognition data from IHI AFHS, GEDA, and GSV.

These analyses would address questions about measure validity by assessing whether hospitals with the infrastructure, resources, and prior experience expected to facilitate Age-Friendly care are indeed reporting higher levels of positive attestation. It addresses burden by identifying which domains are least implemented and may require additional support or guidance for hospitals; equity implications of burden could be assessed by examining performance across hospital types, including rural, safety-net, and smaller institutions.

As a final set of analyses under this component focused on effectiveness, we would assess whether positive attestation patterns are associated with performance on existing quality indicators in other programs/domains (both upstream and downstream). As an example of an upstream hypothesis, panelists hypothesized that hospitals that score better on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) domains of communication with providers and quietness of the hospital environment¹⁷ would have higher levels of positive attestation. Downstream, we would examine performance on existing clinical outcome measures such as fall rates, incidence of pressure ulcers, and malnutrition scores, all of which are relevant to the domains of mobility, mentation, and overall vulnerability addressed by the Age-Friendly measure. These outcome measures are captured in data sources from Vizient, Premier, AHRQ and the CMS IQR Program. These analyses also assess equity by identifying whether associations hold across all types of hospitals.

Building on the second component, the third component would involve creating a positive deviance sample of 20–25 hospitals. Specifically, we would identify hospitals that featured a positive attestation pattern (i.e., all/mostly yes responses) but that have characteristics that are not typical for that pattern. Through qualitative interviews in this sample, we could assess multiple concerns raised by the panel. It assesses item-level validity by confirming whether "positive deviants" do in fact have the domains implemented. It assesses reliability over time by asking them to report on attestation statements – both those involved in the initial attestation as well as those in other roles familiar with inpatient care processes. If there are minimal concerns about reliability, then these interviews would also serve to understand what resources, strategies, or contextual factors enabled them to positively attest where similar hospitals did not. In turn, these practices may inform broader adoption and implementation strategies that support hospitals that appear to be behind in their readiness to implement Age-Friendly care. This would address burden-related concerns by uncovering concrete strategies that facilitate adoption and positive attestation even in less-resourced settings. It informs equity by highlighting effective practices in resource-constrained hospitals that could guide targeted support efforts.

Longer-Term Evaluations

To understand the impact of the Age-Friendly Hospital Measure on its broad goal of improving outcomes for older adults, panelists suggested a set of longer-term evaluations aimed at understanding effectiveness by measuring both clinical outcomes and structural factors that may shape the magnitude of gains in these outcomes. By using multiple years of attestation and outcomes data, these studies will also feature stronger approaches to causal inference – effectively assessing whether changes in outcomes for older adults can be attributed to the measure and underlying changes in care it spurred.

As proposed by the panel, one core strategy is a longitudinal, outcomes-based assessment to evaluate whether hospitals that positively attest to the Age-Friendly Hospital Measure show improvements in key clinical outcomes over time. Outcomes to assess, as proposed by the experts, include 30-day readmission rates, inpatient falls, and incidence of delirium, conditions that are common among older adults and closely linked to the domains of the measure. To provide a more holistic picture, this analysis should also incorporate post-acute care outcomes, using home health assessments and nursing home quality metrics, to assess whether the benefits of Age-Friendly inpatient care extend into post-acute settings. Potential data sources include CMS claims data (e.g., MEDPAR), Home Health Compare, and SNF quality reporting metrics. Additional indicators such as post-acute care utilization (e.g., SNF use) and successful discharge to home would further strengthen the evaluation.

The panelists also emphasized the importance of evaluating structural and resource-related factors that may influence both attestation rates and downstream outcomes. This includes analysis of hospital-level characteristics such as nurse-to-patient ratios, availability of geriatric-trained staff, presence of geriatric care models, and the financial or operational capacity of hospitals and health systems. Understanding these contextual factors can help explain variation in performance and guide where targeted investments or technical support may be most needed to ensure the equitable impact of Age-Friendly care.

Lastly, panelists suggested incorporating patient experience as a critical set of outcomes to evaluate. These patient-reported outcomes offer an important complement to traditional outcome measures, resulting in a more holistic assessment of impact. To capture domains such as communication, care transitions, and emotional support, Press Ganey data may be useful. Panelists also suggested developing and piloting patient experience questions specific for older adults reporting on Age-Friendly care, which could be appended to existing HCAHPS surveys.

Summary of Studies

In summary, the panelists propose a series of short- and long-term evaluations that leverage multiple, complementary data sources to address their key concerns about the Age-Friendly Hospital Measure. Table 4 provides an overview of each study, including the target population, methods, the specific dimensions of concern addressed, and the proposed timeline.

Table 4: Prioritized Studies to Evaluate the Age-Friendly Hospital Measure

Study	Target Population and Methods	Key Dimensions of Concern to Address	Timing
1	Qualitative Interviews with the AFHS lead at 20-25 hospitals Random Sample	Validity: Explore how hospitals interpret and implement attestation criteria Reliability: Assess variation in how different staff/roles define and respond to “yes” attestations Burden: Identify which domains are most challenging to implement, align poorly with existing workflows, or required additional resources Equity: Include diverse hospitals to assess resource-related barriers and disparities in adoption	Early 2026 (Hospitals submit calendar year 2025 data April 1 – May 15, 2026)
2	National Hospital Attestation Study Data sources: - IQR attestation data - IHI/ACEP/ACS participation data - AHA Survey data - HCAHPs data - Outcomes data from: Vizient, Premier, or AHRQ HCUP data	Validity: Assess correlation between hospital infrastructure/support/experience and positive attestation Burden: Identify which domains are least implemented and may require additional support or guidance Equity: Analyze uptake across hospital types (rural, safety-net, size). Identify whether associations hold across varying hospitals. Effectiveness: Assess whether positive attestation patterns are associated with performance on existing quality indicators in other programs/domains	After attestation data is available (possibly Fall 2026); can build initial analytic dataset with current IQR data.
3	Qualitative Interviews with the AFHS lead at 20-25 hospitals Positive Deviance Sample (those with positive attestation from groups that otherwise had low/lower levels)	Validity (item-level): Confirm whether positive deviants implement domains as attested Reliability: Assess consistency of attestation over time Burden: Uncover successful strategies that drive adoption and positive attestation despite limited resources Equity: Highlight effective practices in resource-constrained settings to inform support efforts	After attestation data is available (possibly Fall 2026)
4	National Hospital Impact Study <u>Goals:</u> 1) Evaluate whether hospitals that attest positively demonstrate better clinical and patient experience outcomes. 2) Evaluate if resource constraints and patient demographics influence equity of implementation and outcomes improvements <u>Data Sources:</u> - IQR attestation data	Effectiveness: Evaluate whether positive attestation predicts better outcomes, and if structural factors shape the magnitude of gains in these outcomes	2027-2028 Once inpatient (MedPAR) data is available for 2025 & 2026 Also consider including home health and SNF data from these years

- CMS claims-based outcomes
- AHA Survey Data
- Home Health Compare data
- SNF Quality Reporting Metrics
- Press Ganey data

Conclusion

The Age-Friendly Hospital Measure marks an important shift toward prioritizing geriatric care in federal hospital quality programs. Its long-term success will depend on how the measure is interpreted, implemented, and ultimately evaluated. This report highlights both the measure's promise and its potential limitations – particularly related to specificity, reliability, burden, and equity. These questions underscore the importance of a rigorous research agenda to assess how hospitals respond to the measure, which domains prove most difficult to implement, and whether positive attestation is associated with meaningful improvements in care and outcomes for older adults. Future work should also explore how hospitals with limited resources can be effectively supported and whether elements of the measure should evolve to include more direct process or outcome components. As national data become available, empirical evidence will be critical to informing measure refinement and ensuring that the goal of advancing Age-Friendly hospital care is fully realized.

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