

HANYS DEEP DIVE AFHS SCALE & SPREAD

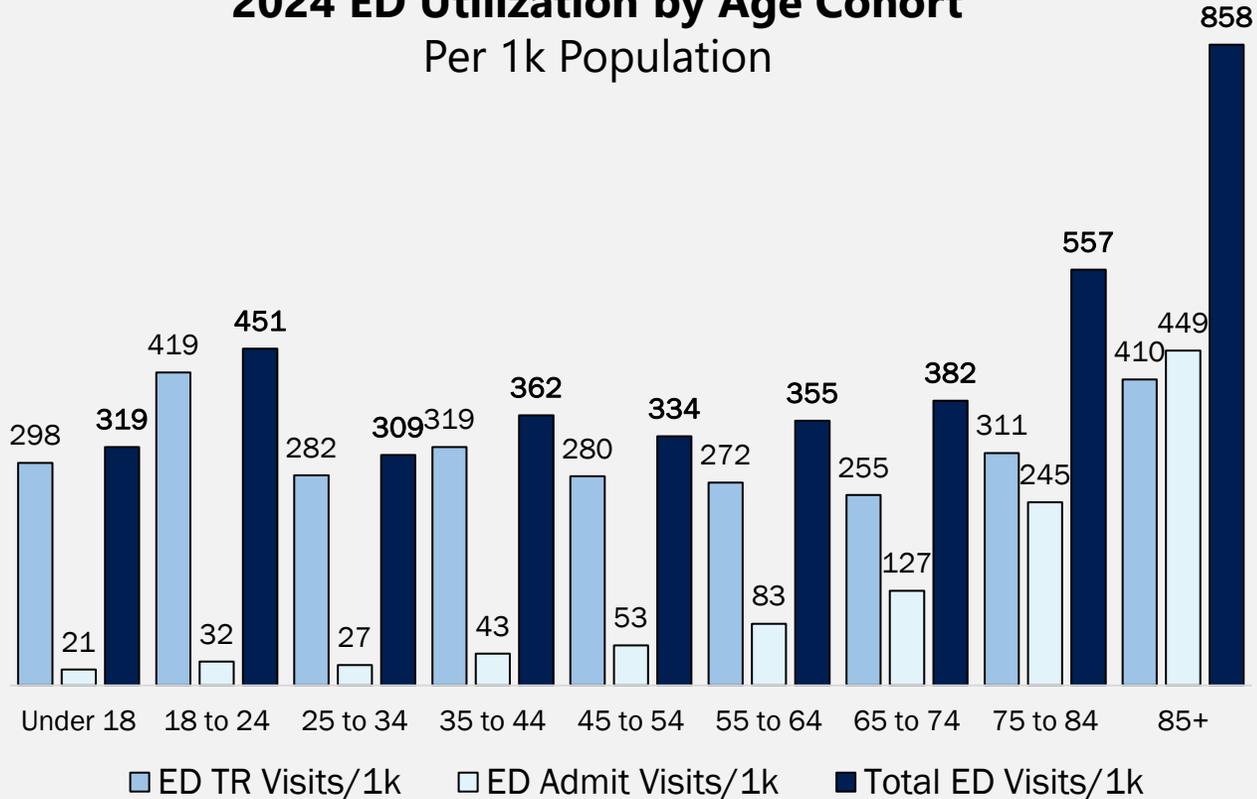
Susan Kwiatek, RN, MBA, DNP, NE-BC
VP, Aging & Supportive Care

June 23rd, 2025

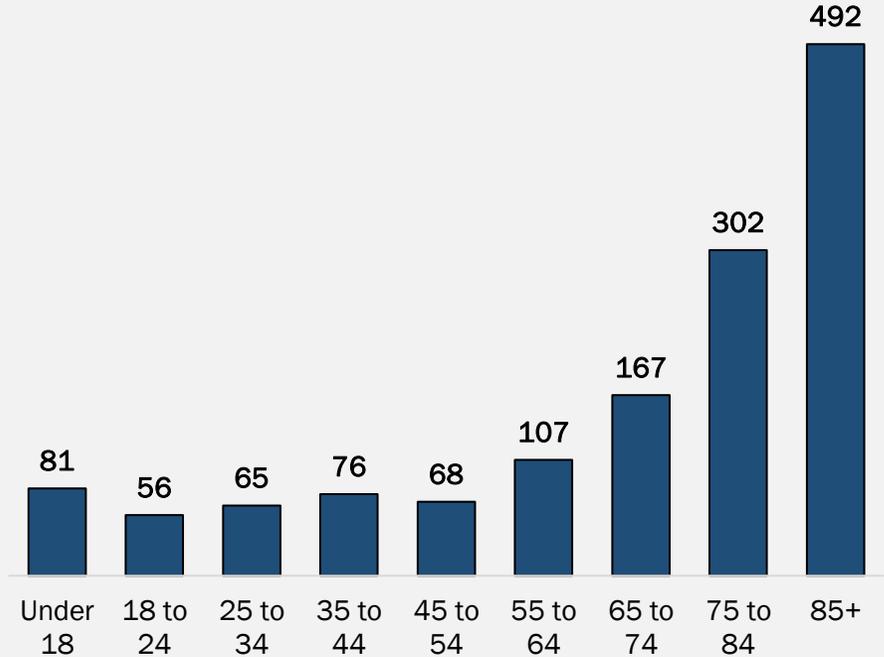
ED & IP Use Becomes Proportionally Higher In 85+ Cohort

NORTHWELL SERVICE AREA RESIDENTS

2024 ED Utilization by Age Cohort Per 1k Population



2024 IP Discharges by Age Cohort Per 1k Population

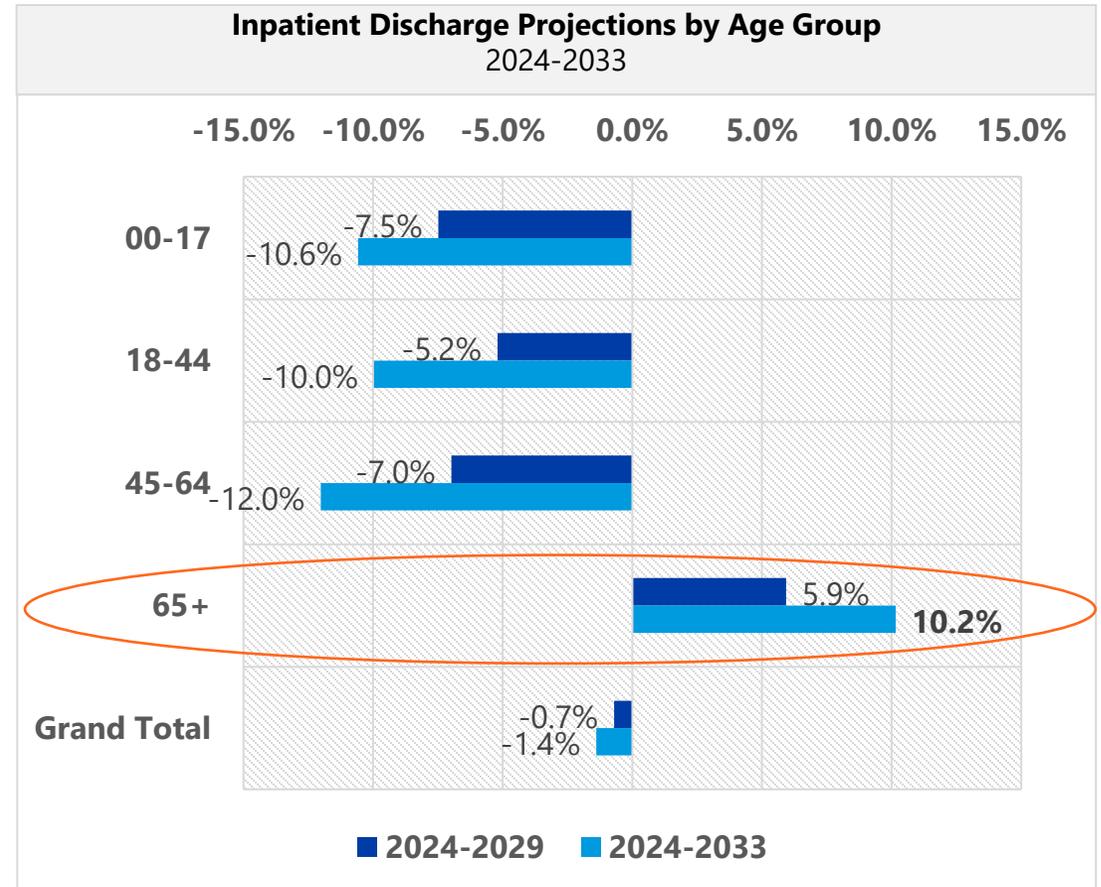
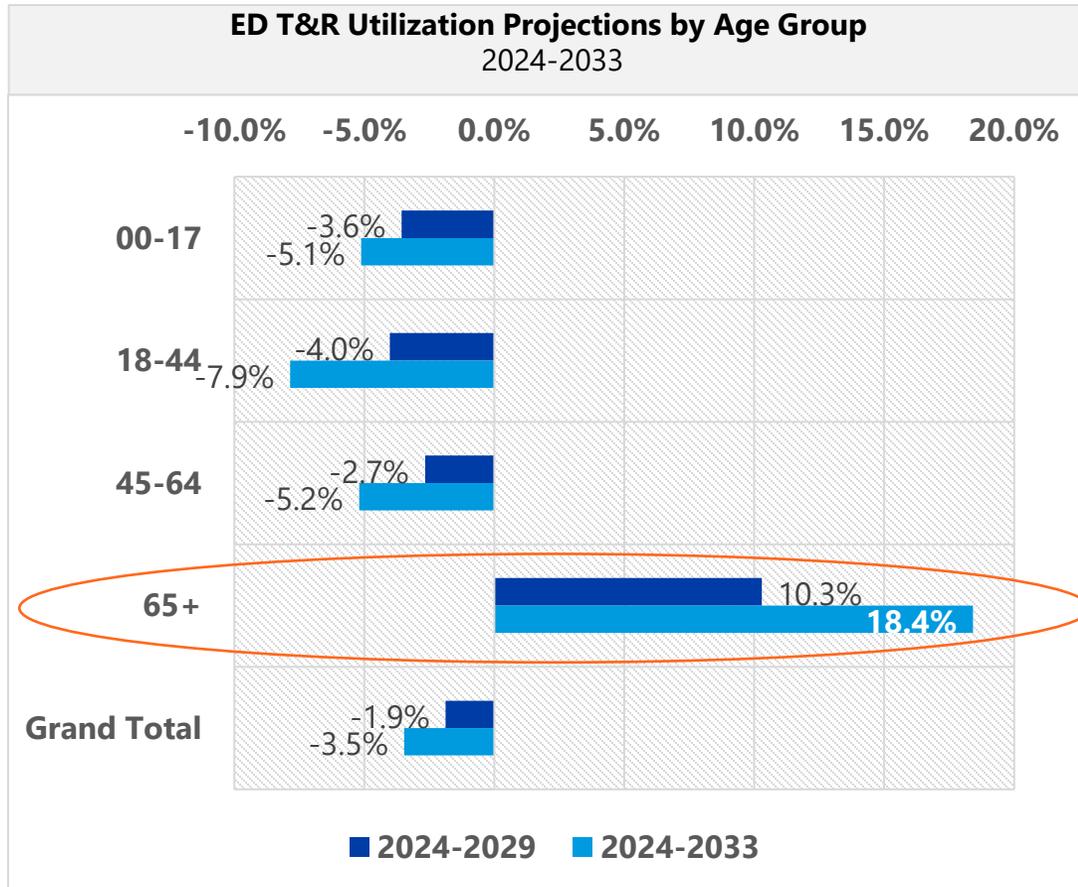


Notes: Data for the year 2024; Source: SPARCS v2025.1.30/unadj/ks; SG2 Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023
Prepared by the Office of Strategic Planning/ks; Brooklyn is not included in graphs

NORTHWELL SERVICE AREA - UTILIZATION PROJECTIONS

ED T&R Utilization And Inpatient Discharges Are Projected To Increase Among 65+ And Decrease Among All Other Age Groups.

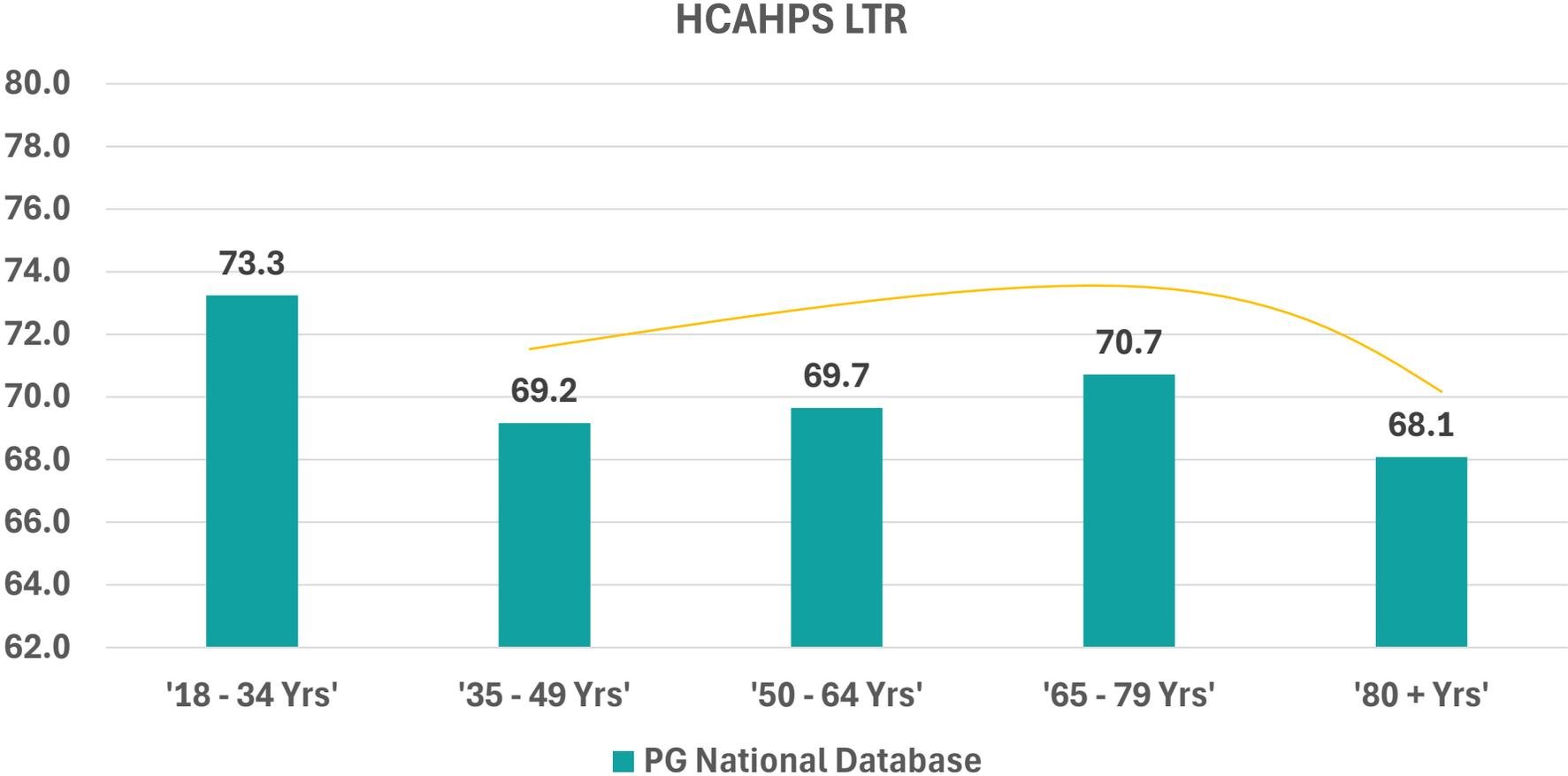
FIVE- AND TEN-YEAR PROJECTIONS, NORTHWELL SERVICE AREA RESIDENTS



Notes: ED T&R only; Inpatient discharges excludes newborns and neonatology; Source: SG2 Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023
Prepared by the Office of Strategic Planning/ks; Brooklyn residents not included

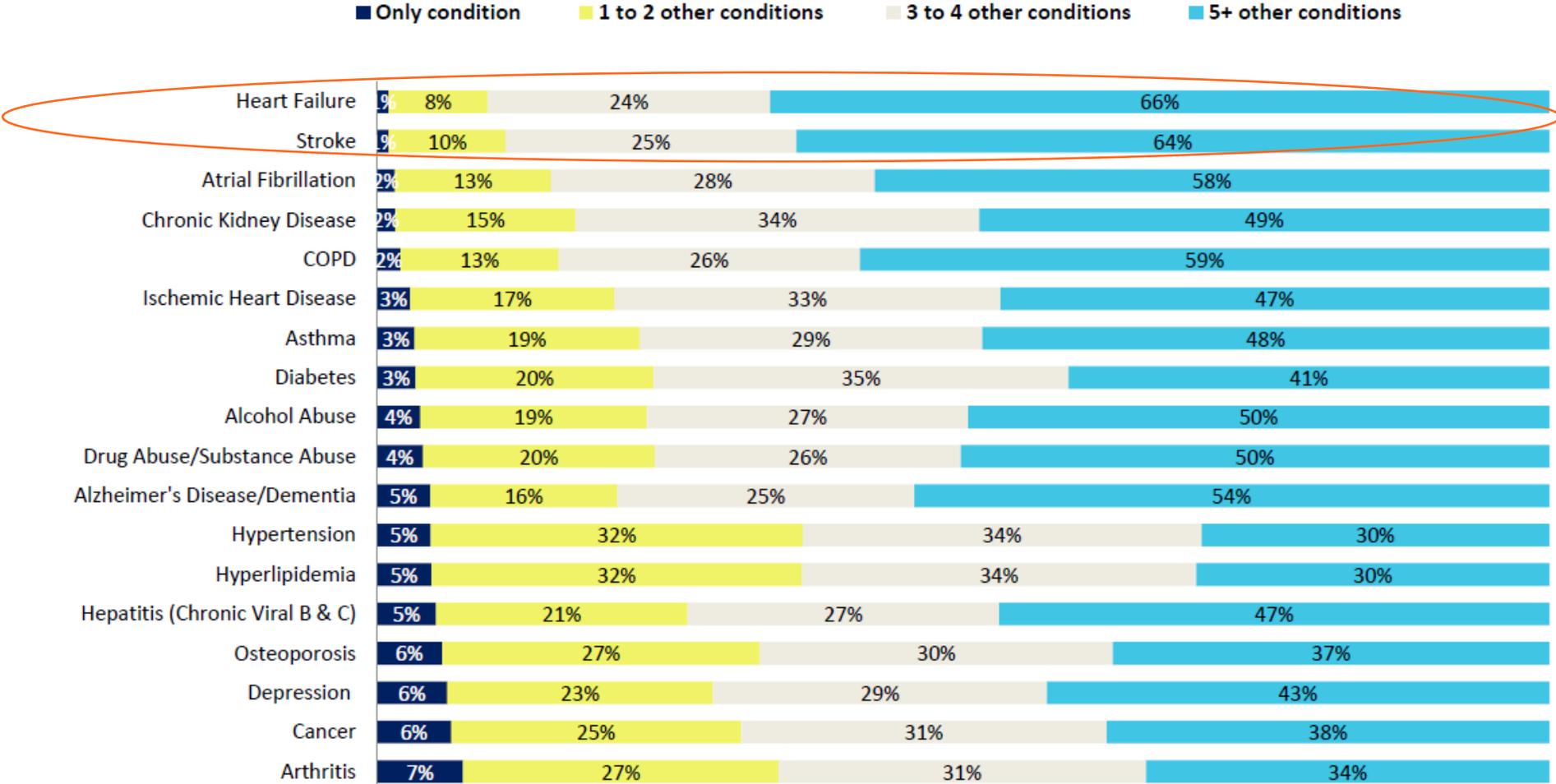
National Patterns in Patient Experience by Age Cohort

LTR is Lowest for 80+ Age Category (HCAHPS Survey)



MULTIPLE CHRONIC CONDITIONS

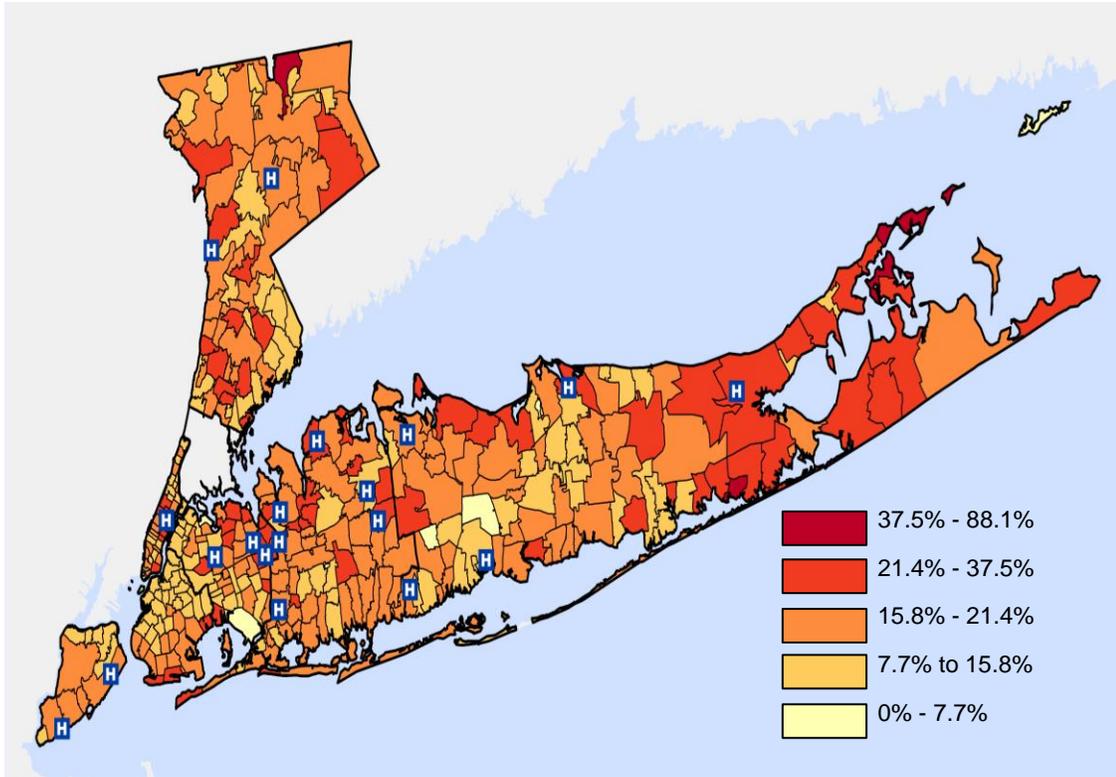
Percentage of Medicare FFS beneficiaries with 21 selected chronic conditions.
Only 1% of Heart Failure Patients 65+ only had Heart Failure, while 66% had 5+ other chronic conditions.
 CMS MEDICARE BENEFICIARIES 2021



DEMOGRAPHIC OVERVIEW

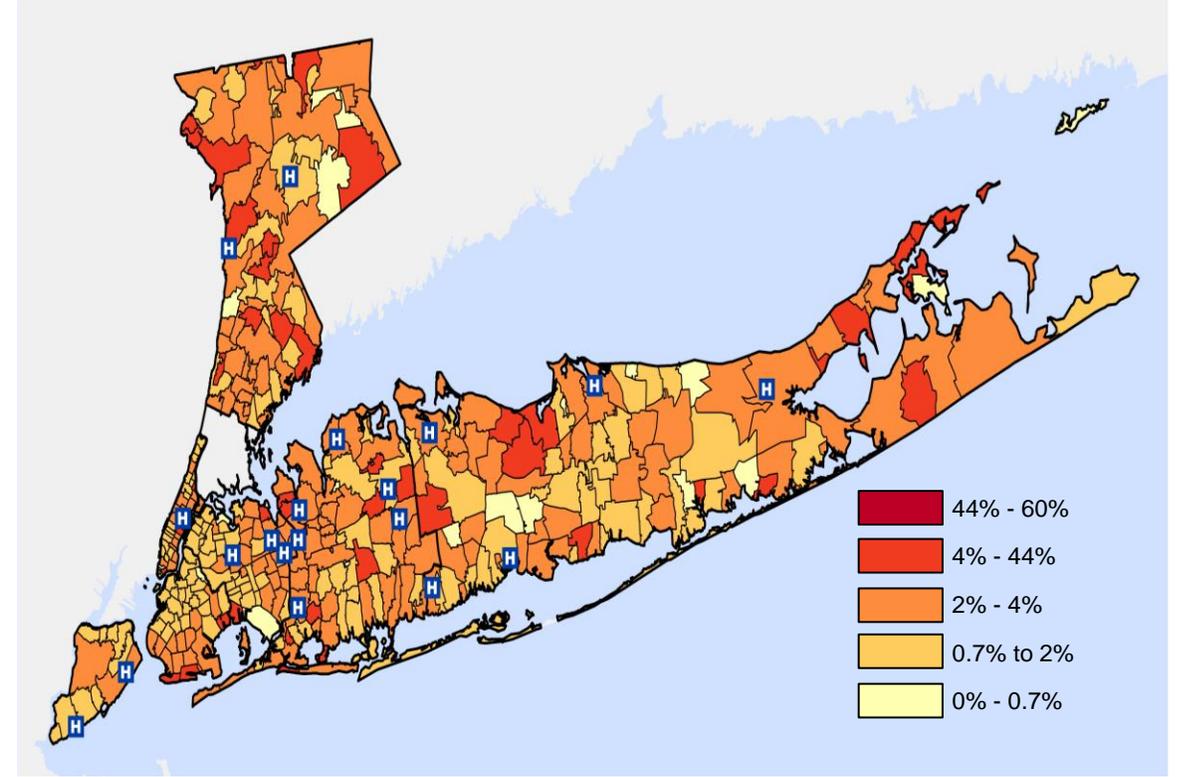
Northwell Service Area & Brooklyn, 2023

Percent of Population 65+



Source: 2019-2023 American Community Survey 5-Year Estimates (accessed 4/1/24) Table: B01001;
Prepared by the Office of Strategic Planning/ks

Percent of Population 85+

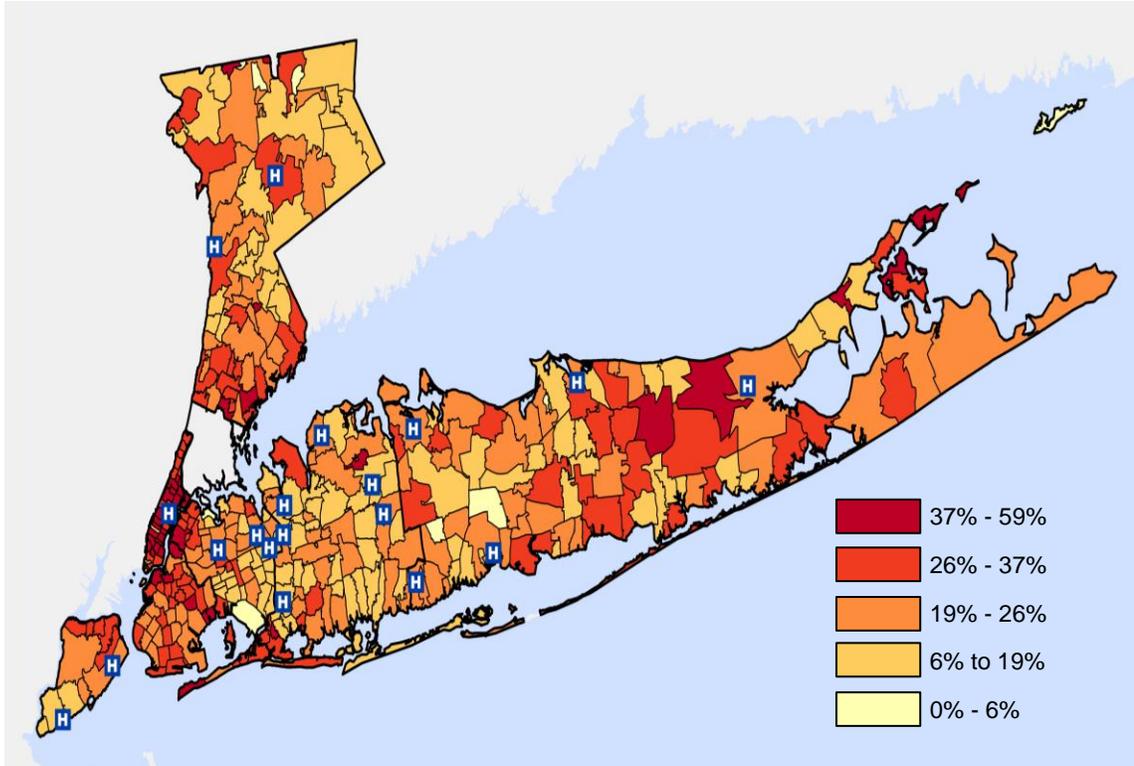


Source: 2019-2023 American Community Survey 5-Year Estimates (accessed 4/1/24) Table: B01001;
Prepared by the Office of Strategic Planning/ks

DEMOGRAPHIC OVERVIEW

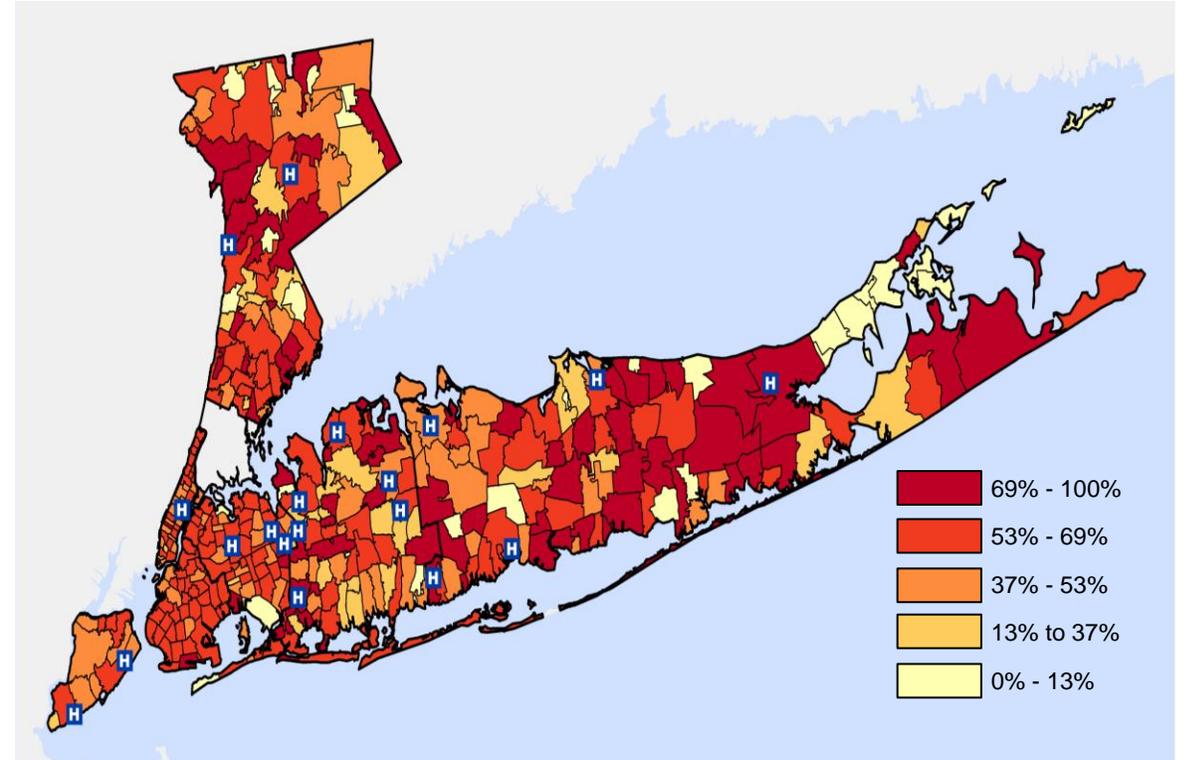
Northwell Service Area & Brooklyn, 2023

Percent of Population 65+ Living Alone



Source: 2019-2023 American Community Survey 5-Year Estimates (accessed 4/1/24) Table: B09020;
Prepared by the Office of Strategic Planning/ks

Percent of Population 65+ Rent Burden

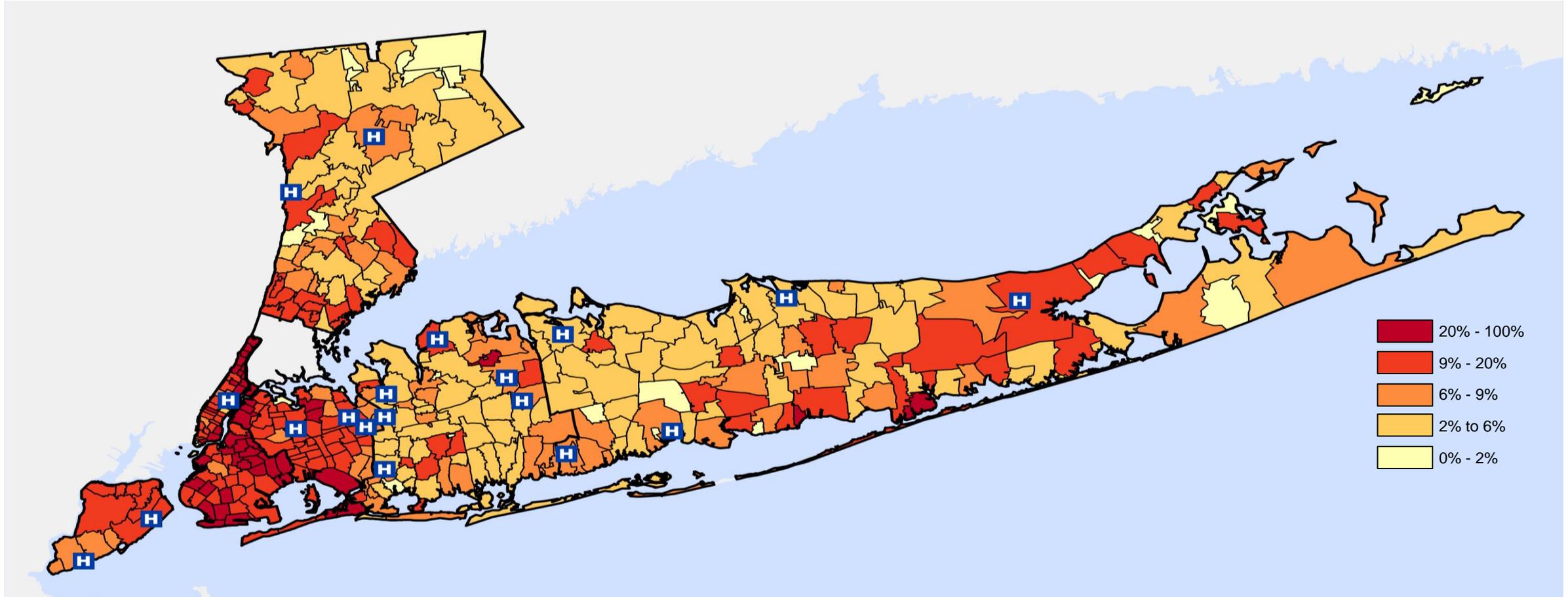


Source: 2019-2023 American Community Survey 5-Year Estimates (accessed 4/1/24) Table: B25072;
Prepared by the Office of Strategic Planning/ks

DEMOGRAPHIC OVERVIEW

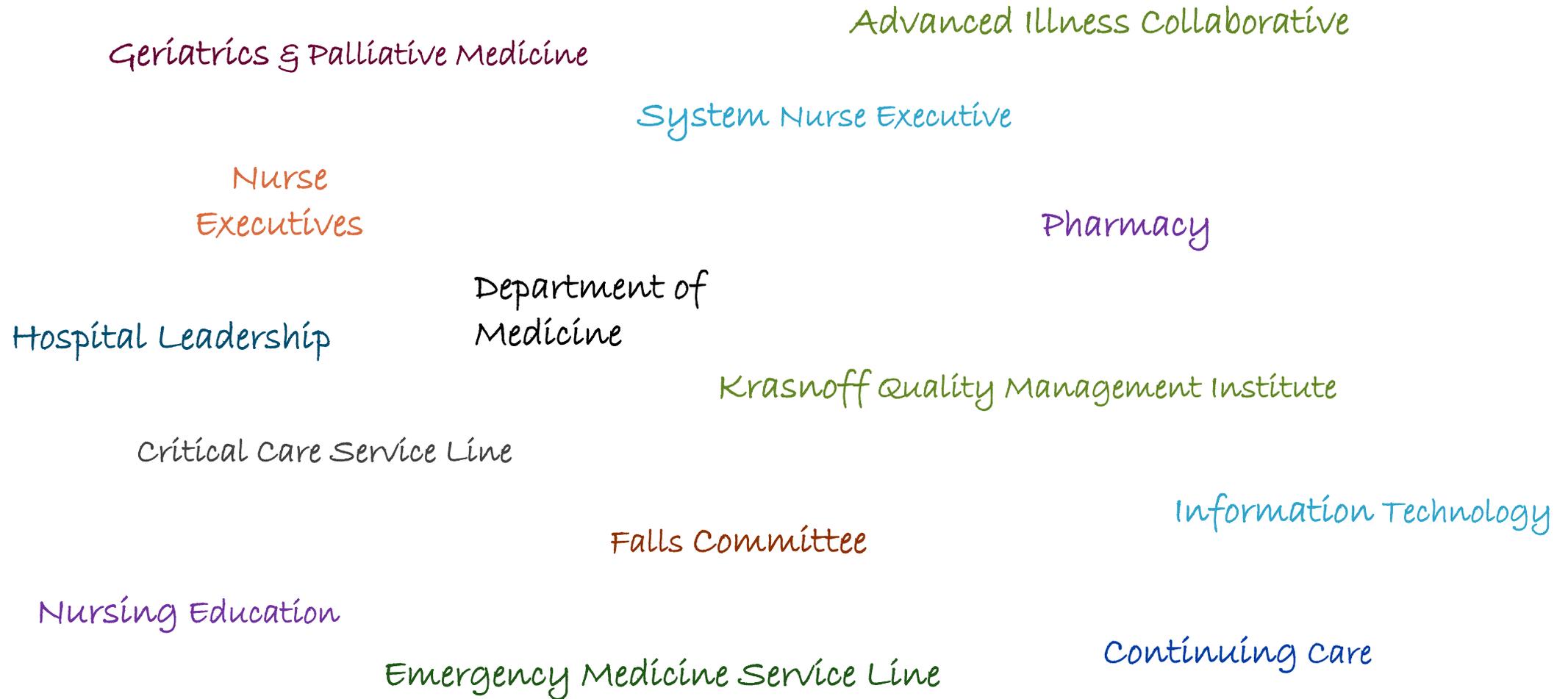
Northwell Service Area & Brooklyn, 2023

Percent of Population 65+ Below Poverty

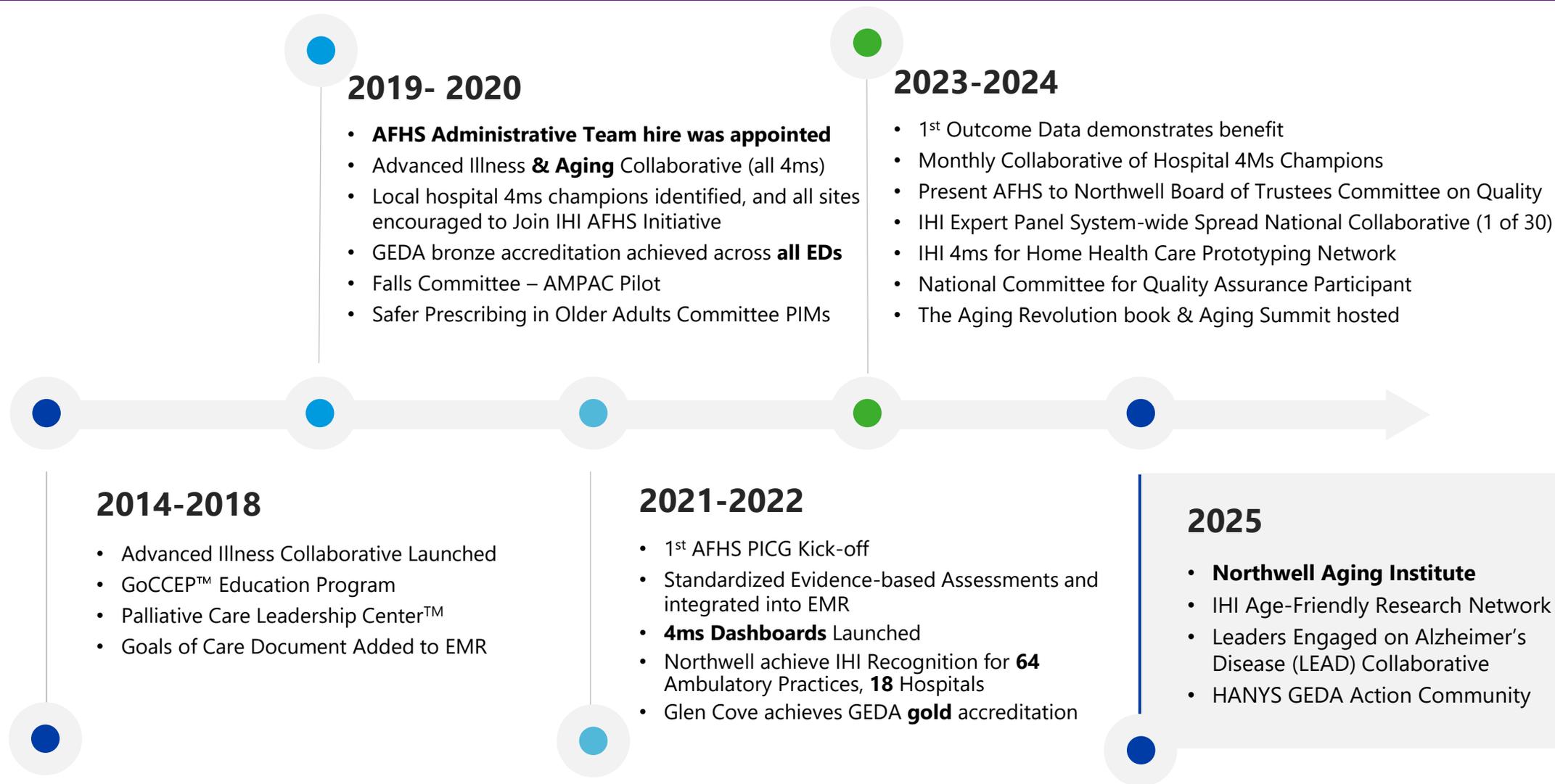


Source: 2019-2023 American Community Survey 5-Year Estimates (accessed 4/1/24) Table: B17001;
Prepared by the Office of Strategic Planning/ks

STRONG COLLABORATIVE CULTURE-PARTNERS & STAKEHOLDERS



AGE-FRIENDLY HEALTH SYSTEM JOURNEY AT NORTHWELL HEALTH



STEPWISE PROCESS TO AN AGE-FRIENDLY HEALTH SYSTEM

STEP 1: ASSESSMENT

STEP 2: RECOGNITION

STEP 3: STRATEGIC PLAN

STEP 4: PRACTICE STANDARDIZATION/COLLABORATION

STEP 5: METRICS

STEP 6: CHOOSE PILOT HOSPITALS

STEP 7: DASHBOARDS

Inventory of Northwell Aging and Advanced Illness Services

		FHH	LIJVS	LIJMC	NSUH	GC	HH	PV / SY	SS	Mather	PBMC	LHH	SIUH	PMH	NWH
Post Acute	Assisted Living Facility Program	-	✓	✓	✓	-	-	-	-	-	-	✓	-	-	-
	Skilled Nursing Facility	-	✓	-	✓	-	-	-	-	-	-	-	-	✓	-
	Hospice	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Home Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Telehealth	TeleEMS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	E-SNF Relationships*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Education/Research	Geriatric Medicine Fellowship	-	-	✓	✓	-	-	-	-	-	-	-	✓	-	-
	Hospice and Palliative Care Fellowship	-	-	✓	✓	-	-	-	-	-	-	✓	-	-	-
	Collaborative for Aging and Advanced Illness Research and Education (CAARE)	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-
	Older Adult COVID database	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-
	Palliative Care Leadership Center (CAPC)	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-
	GoCCEP™ (Goals of Care Conversation Project)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Advanced Illness and Aging Collaborative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Age-Friendly i-Learn Education Module	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

**INVENTORY OF NORTHWELL AGING AND
ADVANCED ILLNESS SERVICES**

		FHH	LIJVS	LIJMC	NSUH	GC	HH	PV / SY	SSUH	Mather	PBMC	LHH	SIUH	PMH	NWH	
Inpatient	Geriatric Inpatient Consultation	-	-	✓	✓	✓	✓	-	-	-	-	✓	✓	✓	-	
	Palliative Inpatient Consultation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Inpatient Palliative Care Unit	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	
	Geriatric ED Accreditation (GEDA)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Acute Care for Elderly (ACE) Unit	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-	
	Geriatric Orthopedic Hospitalist Co-Management (GOHCo)	✓	✓	✓	-	-	✓	-	-	-	-	-	-	-	-	
	Geriatric Surgical Verification	-	-	-	-	*	*	-	-	-	-	-	-	-	*	
	Joint Commission Advanced Palliative Care Certification	-	-	✓	✓	-	✓	-	-	-	-	✓	✓	-	-	
	Hospital-Based Hospice Beds	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-	-	✓	✓
	Geriatric Psychiatry - Inpatient	-	-	✓	✓	✓	-	✓	-	-	-	-	✓	-	✓	-
	Hospital Elder Life Program (HELP)	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	
	NICHE Designation	-	✓	✓	✓*	✓	-	-	-	-	-	-	✓	-	✓	-
	Magnet Hospital	-	-	✓	✓	✓	✓	✓	-	✓	-	-	-	✓	-	✓
	U.S. News and World Report 2024	29	29	29	14	HP	31	HP	HP	HP	HP	-	23	HP	-	HP
	Advanced Practice Nurses – Geriatrics / Palliative	✓	-	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-	-
Outpatient	Geriatric Outpatient Consultation	-	-	✓	✓	✓	-	-	-	-	-	✓	✓	✓	-	
	Palliative Outpatient Consultation	✓	-	✓	✓	-	-	-	-	-	✓	✓	-	✓	-	
	Geriatric Psychiatry - Outpatient	-	-	✓	✓	✓	-	-	-	-	-	-	✓	-	-	
Community Based	Home-based Primary Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	
	Caregiver Program/ Center	-	-	-	✓	✓	✓	-	-	-	✓	-	-	-	✓	
	Bereavement Groups/Support for Patients with Advanced Illness	✓	-	✓	✓	✓	-	-	✓	-	-	✓	✓	✓	✓	

AGE-FRIENDLY HEALTH SYSTEM ASSESSMENT

Education

- Geriatric Fellowship Program (FT/PT)
- Palliative Care Fellowship (FT/PT)
- *GoCCEP™*
- Developed Age Friendly i-learn Education Module
- CAPC Palliative Care Leadership Center

Clinical Programs

- Geriatric Medicine
- Palliative Medicine
- Geriatric Psychiatry
- Hospice
- Long Term Care-Stern & Orzac and SNF/ALF relationship
- Home Care
- Geriatric-Ortho Co-Management (GOHCO)
- Geriatric EDs

Initiatives

- Dementia
- Caregiver Programs/Centers
- Caregiver BERG
- *Safe Prescribing*
- Discharge Planning
- Alignment with Medicine Service Line to Educate and Standardize 4Ms in the Ambulatory Practices and Make Modifications to EHR

Collaboration

- Hospital/ Nursing
- Pharmacy
- *Falls Committee*
- Speech Pathology
- *Advanced Illness and Aging Collaborative*
- *Critical Care Service Line*
- Telehealth

STEPWISE PROCESS TO AN AGE-FRIENDLY HEALTH SYSTEM

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STEP 7: DASHBOARDS

WHERE ARE WE WITH 4MS SPREAD IN OUR SYSTEM

Age-Friendly Participant

LIJ Valley Stream
Northern Westchester Hospital
South Shore University Hospital
Staten Island University Hospital
Zucker Hillside Hospital
Orzac Center for Rehabilitation

Committed to Care Excellence

Forest Hills Hospital
Glen Cove Hospital
Mather Hospital
Plainview Hospital
Syosset Hospital
Phelps Memorial Hospital
Peconic Bay Medical Center
North Shore University Hospital
Long Island Jewish Medical Center
Huntington Hospital
Lenox Hill Hospital
Stern Family Center for Rehabilitation
North Shore Home Care - Westbury
North Shore Home Care - Staten Island
North Shore Home Care - Lake Success
North Shore Home Care - Tarrytown
North Shore Home Care - New York
Peconic Bay Home Health Services

PARTICIPANT RECOGNITION FOR 64 AMBULATORY PRACTICES

<u>Northwell Health Primary Care Practice Sites</u>		
10 Medical Plaza, Suite 303, Glen Cove	362 N. Broadway, 2nd Floor (Sleepy Hollow)	500 W. Main Street, Suite 204, Babylon
100 Manetto Hill Road, Suite 312, Plainview	200 S. Broadway, Ste 2-5 (Tarrytown)	522 Old Country Road, Plainview
1001 Franklin Avenue, Suite 106, Garden City	205 S. Ocean Avenue, Patchogue	560 Northern Blvd., Suite 203, Great Neck
101 St. Andrews Lane, Glen Cove	211-16 Union Tpke., Bayside	6144 Route 25A, Wading River
410 Lakeville Rd New Hyde Park	2119 Merrick Road, Merrick	70 Glen Cove Road, Suite 601, Roslyn Heights
1085 Park Avenue, Suite 1N, New York City	22 West 15th Street, 1st Floor, New York City	70 N. Country Road, Port Jefferson
110 East 59th Street, Suite 10C, New York City	225 Community Drive, Suite 130, Great Neck	70 W. Main Street, Oyster Bay
1019 Fort Salonga Road, Northport	23-25 31st Street, 3rd Floor, Astoria	733 Sunrise Hwy., 3rd Floor, Lynbrook
115-06 Beach Channel Drive, Rockaway Park	242 Mason Avenue, Staten Island	733 Sunrise Hwy., 1st Floor, Lynbrook
1165 Northern Blvd., Suite 300, Manhasset	25 Central Park Road, Plainview	777 Larkfield Road, Commack
120 New York Avenue, Suite 7W, Huntington	250 E. Main Street, 2nd Floor, Bay Shore	850 Fulton Street, Suite 2, Farmingdale
121 W. 20th Street, New York City	256-11 Union Tpke., Glen Oaks	865 Northern Blvd., Suite 102, Great Neck
122 E. 76th Street, Suite 1A/1C, New York City	260 Main Street, Islip	9 Brookside Drive, Smithtown
1272 E. Main Street, Riverhead	291 Sunrise Hwy., Lindenhurst	927 Park Avenue, New York City
152 Islip Avenue, Islip	300 Franklin Avenue, Valley Stream	95-25 Queens Blvd., 3rd Floor, Rego Park
1575 Hillside Avenue, Suite 102, New Hyde Park	3001 Expressway Drive North, Suite 102, Islandia	755 N. Broadway, Suite 417 (Phelps)
175 E. Main Street, Suite 104, Huntington	321 Crossways Park Drive, Woodbury	440 South Riverside Avenue (Croton)
178 E. 85th Street, 2nd Floor, New York City	36-29 Bell Blvd., Suite 201, Bayside	11 Ashford Avenue, 2nd Floor (Dobbs Ferry)
1872 Bellmore Ave., Bellmore	369 E. Main Street, East Islip	20 Beacon Hill Drive (Dobbs Ferry)
200 Howells Road, Bay Shore	375 Seguin Avenue	100 S. Highland Avenue (Ossining)
2001 Marcus Avenue, Suite S160, New Hyde Park	480 Forest Avenue, Locust Valley	
2001 Marcus Avenue, Suite N204, New Hyde Park	487 Lake Avenue, St. James	

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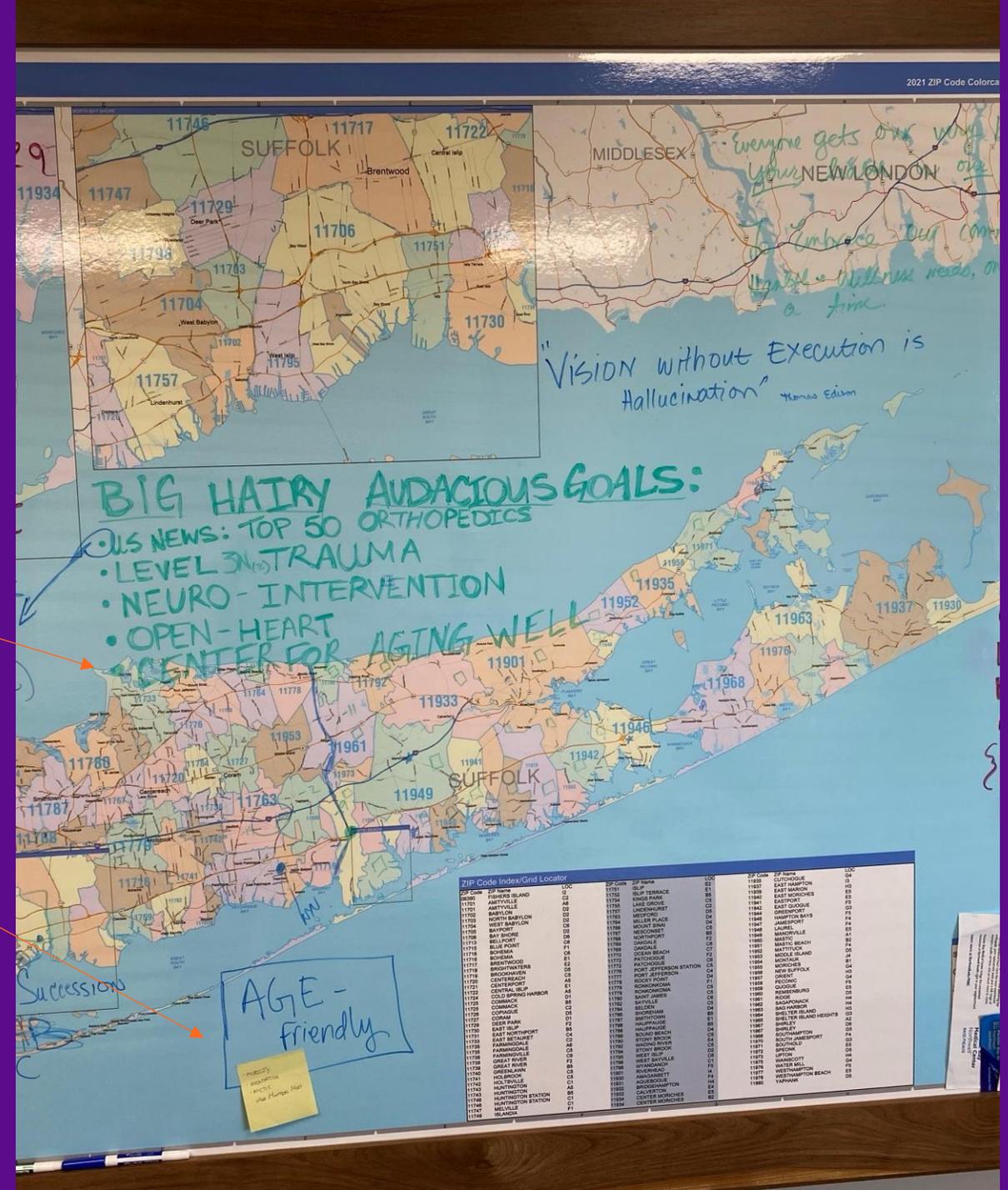
STEP 6: CHOOSE PILOT HOSPITALS

STEP 7: DASHBOARDS

Leadership Commitment!

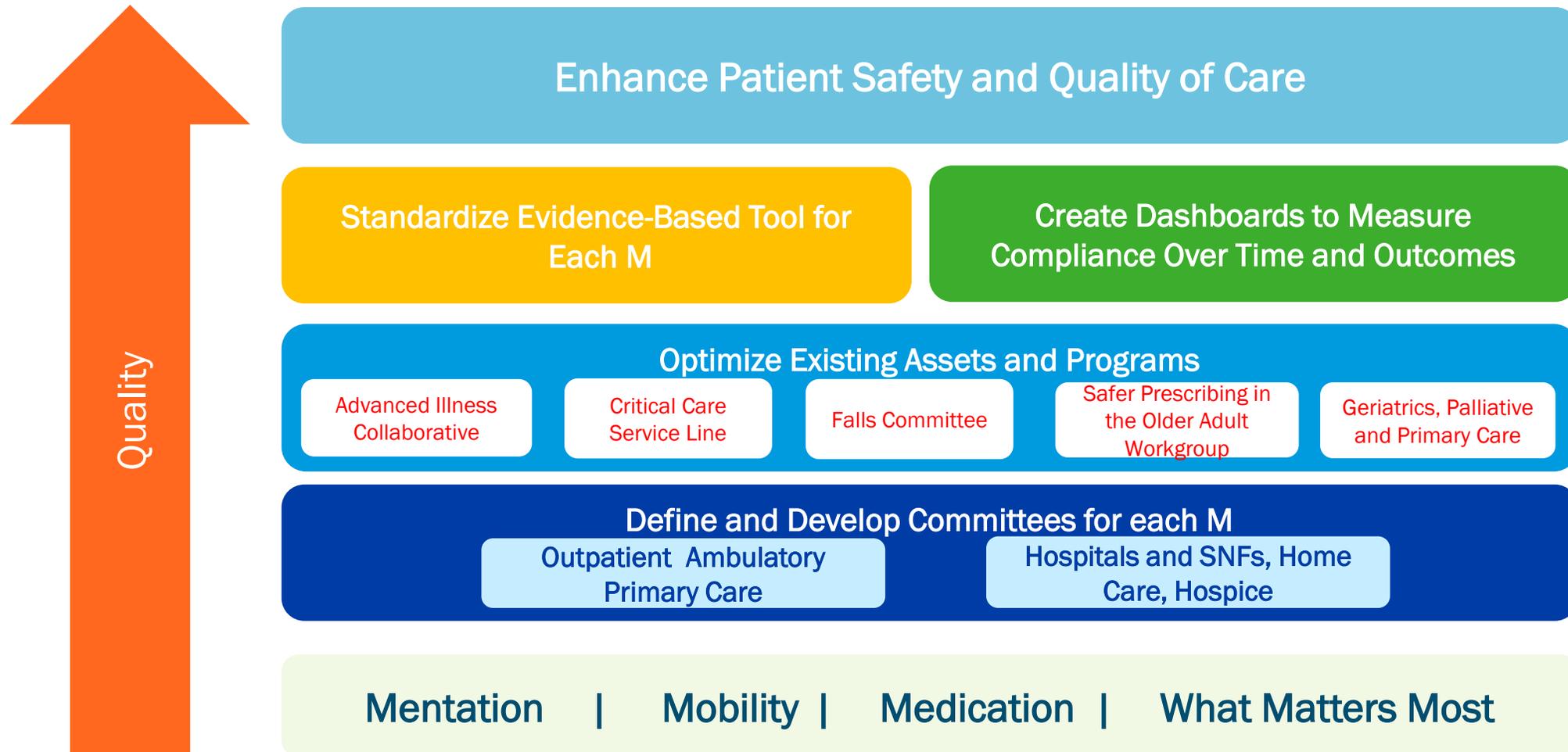
Big Hairy Audacious Goals at Peconic Bay Medical Center

Center for Aging Well
Age-Friendly



STEP 3: STRATEGIC PLAN

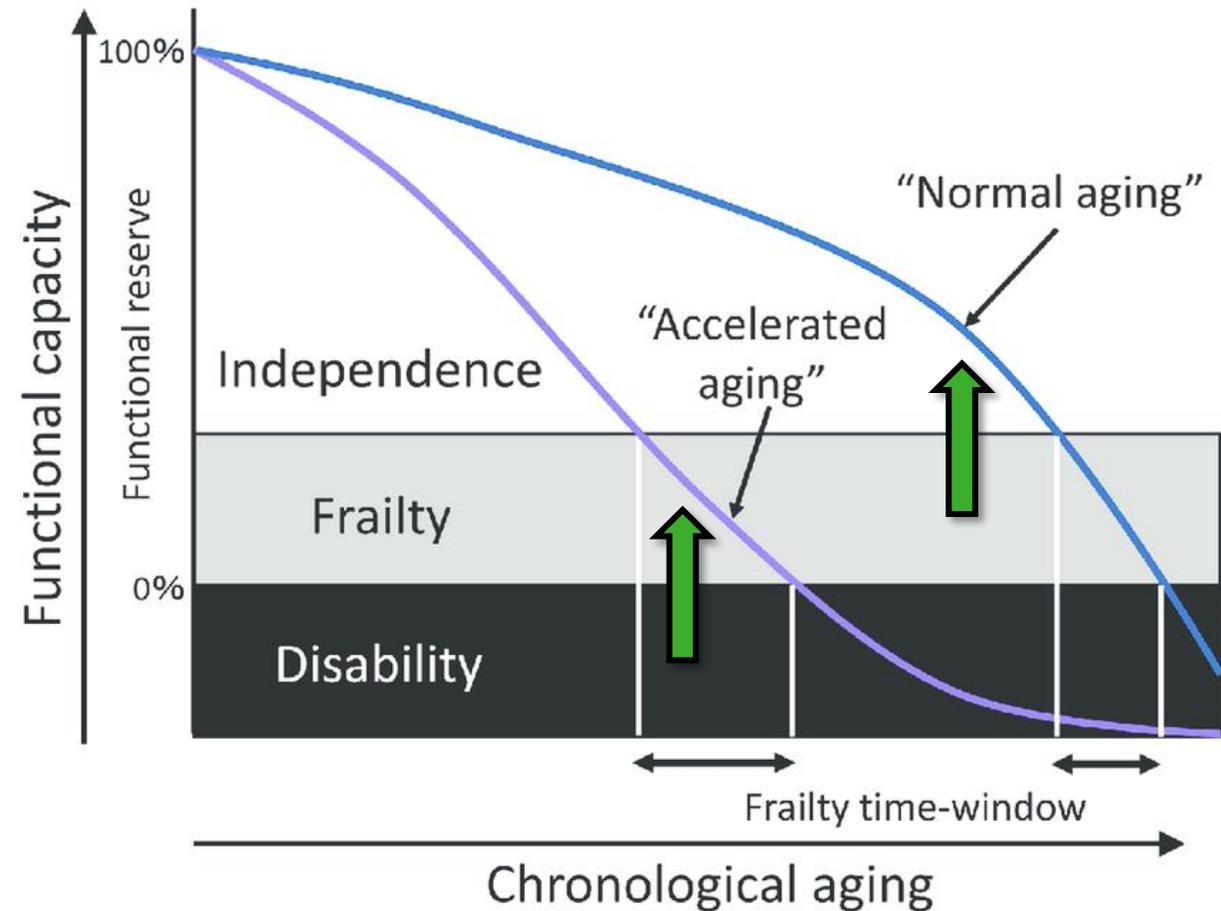
AGE-FRIENDLY HEALTH SYSTEM – INTEGRATED



PROPOSED ENTERPRISE AGING STRATEGIES

Northwell Master Plan on Aging

- 1 Age-Friendly Initiatives
- 2 Caregiving Strategy
- 3 Dementia Care Strategy
- 4 Aging at Home Strategy
- 5 Ambulatory Strategy
- 6 QoL Strategy
- 7 Longevity Strategy



↑ = Healthy Aging & Supportive Care Efforts

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STANDARDIZATION 4M ASSESSMENTS

- **What Matters Most** – *Advanced Illness and Aging Collaborative*
 - Goals of Care Conversations - WMM
- **Mentation** – *Critical Care Service Line*
 - Critical Care – CAM-ICU
 - Non-Critical Care – b-CAM
- **Mobility** – *Falls Committee*
 - Nursing Admission Assessment and Daily Flowsheet – AMPAC 6 Clicks
- **Medication** – *Safer Prescribing in the Older Adult Workgroup*
 - Identified potentially harmful medications
 - Medication Surveillance Report
 - Clinical Decision Support Pathway

WHAT MATTERS MOST *ADVANCE ILLNESS & AGING COLLABORATIVE*

GoCCEP™ education uses a blended learning, multimodal educational methodology in a safe learning environment, using simulation as a reflective educational tool consisting of:

Required pre-work (1 hour total)

- ❖ Two online modules available in iLearn (45 minutes)
- ❖ Pre readings (15 minutes)

Virtual Session (3 hours on Zoom)

- ❖ Instructor lead didactic review and Q&A
- ❖ Two GoCCEP™ instructor lead standardized patient encounters with feedback sessions ~ including a patient encounter and distraught family member encounter
- ❖ Culminating with a group debrief

MOBILITY- FALL COMMITTEE



Fall Risk Assessment



AM-PAC 6 CLICKS
a) Basic Mobility Assessment
b) Daily Activity Assessment



Pilot Study
4 Units, 3
Hospitals

- User Engagement (Survey Results)
- Mobility Score (Minimize Deconditioning)
- Falls
- Improve Discharge Disposition insight and recommendations
- Workforce Injuries



MENTATION CRITICAL CARE SERVICE LINE

Critical Care service line = The ABCDEF bundle.

The ABCDEF bundle is an evidenced-based bundle of care to optimize care and outcomes for patients in critical care.

A - Assess, prevent and manage pain

B - Spontaneous awakening and spontaneous breathing trials

C - Choice of analgesia, sedation

D - Assess, prevent and manage delirium

E - Early mobilization and exercise

F - Family engagement and empowerment

CAM-ICU assessment utilized in all critical care units

Collaborated with Critical Care service line

b-CAM identified as the assessment of choice in non-critical care areas

Presented to:

- ❖ The Senior VP & Nurse Executive
- ❖ The System Nurse Executive Council
- ❖ The System Nurse Education Council



MEDICATION SAFER RX IN OLDER ADULT WORKGROUP

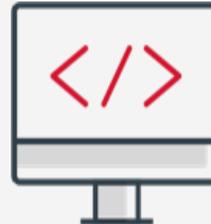
01

Clinical Content
Expertise



02

Clinical Decision
Support



03

Reporting and
Surveillance



LED BY SENIOR DIRECTOR PHARMACY SERVICES, PHARM.D

POTENTIALLY INAPPROPRIATE MEDICATION SAFER RX IN OLDER ADULT

WORKGROUP

Long-acting Benzodiazepines

Consider potentially harmful effects of long-acting benzodiazepines

1. Diazepam
2. Midazolam
3. Temazepam
4. Alprazolam
5. Chlordiazepoxide
6. Clonazepam
7. Lorazepam

Long-acting Opioids

Consider potentially harmful effects of extended-release opioid

1. Fentanyl Patch
2. Morphine Extended Release (ER)
3. Oxycodone Extended Release (ER)

Tricyclic Antidepressants

Consider potentially harmful effects of tricyclic antidepressants

1. Amitriptyline Hydrochloride
2. Imipramine Hydrochloride
3. Nortriptyline Hydrochloride

Anticholinergics

Consider potentially harmful effects of sleep aids, particularly

1. Diphenhydramine

Hypnotics

Consider potentially harmful effects of hypnotics

1. Zaleplon
2. Zolpidem

SURVEILLANCE REPORT - USAGE OF POTENTIALLY HARMFUL MEDICATIONS

SAFER RX IN OLDER ADULT WORKGROUP

Safe Rx for Patients 65 y/o and Older													
<p>Northwell Health Healthcare Analytics</p> <p>Facility: NSUH Unit: More than 10 units selected</p> <p>Medication: More than 10 units selected</p> <p>Comorbidity: More than 10 units selected</p> <p>OCIO- Clinical Analytics</p> <p>Description: Report monitors currently admitted Safe Rx Patients Over 65 and the latest admit order. Total Patients: 143 See Legend for more information</p>													
Patient Full Name	MRN	Date of Birth	Age	Location	Med Ord Name	Order Entry Date	Generic Name	Dose Form	Route	Frequency	Ordering Provider Name	Diagnosis Name	Comorbidity Name
			66	NSUH 3 DSU	oxycodone 5 mg/acetaminophen 325 mg	3/3/2021 4:00:41 PM	acetaminophen-oxycodone	Tablet	Oral	every 4 hours	Dr. smith	Non-ST elevation myocardial infarction (NSTEMI)	Acute myocardial infarction, Fluid and electrolyte disorders, Other ear and sense organ disorders, Other nervous system disorders, Other non-traumatic joint disorders, Peripheral and vascular disease, Atherosclerosis, Residual codes; unclassified, Respiratory failure; insufficiency, arrest (
					oxyCODONE IR	3/3/2021 9:42:17 AM	oxyCODONE	Tablet	Oral	every 8 hours	Dr. smith	Non-ST elevation myocardial infarction (NSTEMI)	Acute myocardial infarction, Fluid and electrolyte disorders, Other ear and sense organ disorders, Other nervous system disorders, Other non-traumatic joint disorders, Peripheral and vascular disease, Atherosclerosis, Residual codes; unclassified, Respiratory failure; insufficiency, arrest (
					diphenhydrAMINE	3/9/2021 3:46:58 PM	diphenhydrAMINE		Oral	every 6 hours	Dr. smith	Non-ST elevation myocardial infarction (NSTEMI)	Acute myocardial infarction, Fluid and electrolyte disorders, Other ear and sense organ disorders, Other nervous system disorders, Other non-traumatic joint disorders, Peripheral and vascular disease, Atherosclerosis, Residual codes; unclassified, Respiratory failure; insufficiency, arrest (
			67	NSUH 2 Monti	belladonna 16.2 mg/opium 30 mg Suppository	3/9/2021 1:38:06 PM	belladonna-opium	Suppository	Rectal	every 8 hours	Dr. smith	Benign prostatic hyperplasia with lower urinary tract symptoms	Asthma, Blindness and vision defects, Hyperplasia of prostate
					morphine - Injectable	3/9/2021 1:38:06 PM	morphine	Solution	IV Push	every 3 hours	Dr. smith	Benign prostatic hyperplasia with lower urinary tract symptoms	Asthma, Blindness and vision defects, Hyperplasia of prostate
					oxycodone 5 mg/acetaminophen 325 mg	3/9/2021 1:38:06 PM	acetaminophen-oxycodone	Tablet	Oral	every 4 hours	Dr. smith	Benign prostatic hyperplasia with lower urinary tract symptoms	Asthma, Blindness and vision defects, Hyperplasia of prostate
										every 6 hours	Dr. smith	Benign prostatic hyperplasia with lower urinary tract symptoms	Asthma, Blindness and vision defects, Hyperplasia of prostate
					diazepam Tablet	3/9/2021 4:02:09 PM	diazepam	Tablet	Oral	every 6 hours	Dr. smith	Benign prostatic hyperplasia with lower urinary tract symptoms	Asthma, Blindness and vision defects, Hyperplasia of prostate

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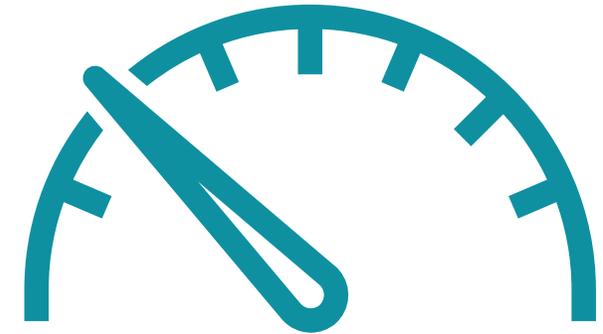
STEP 7: DASHBOARDS

STANDARDIZATION 4M ASSESSMENTS



Choose metrics that impact patient care and help make the business case for an Age-Friendly Health System

- ✓ Compliance with evidence based-assessments over time
- ✓ Length of Stay (LOS)
- ✓ Readmissions
- ✓ Discharge disposition
- ✓ Change in mobility scores
- ✓ Percent of patients assessed for all 4Ms



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STEP 2: RECOGNITION

STEP 3: STRATEGIC PLAN

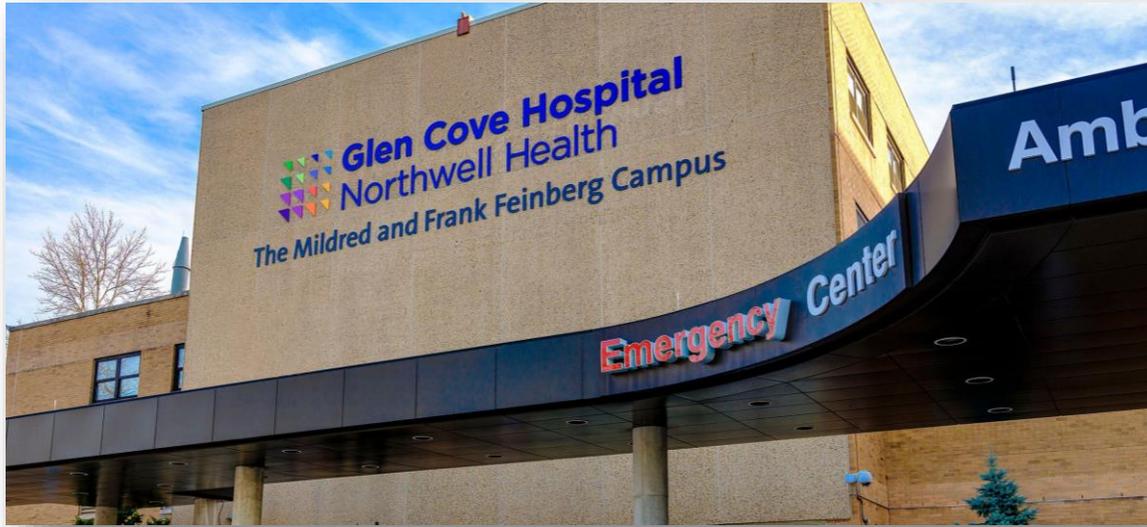
STEP 4: PRACTICE STANDARDIZATION

STEP 5: METRICS

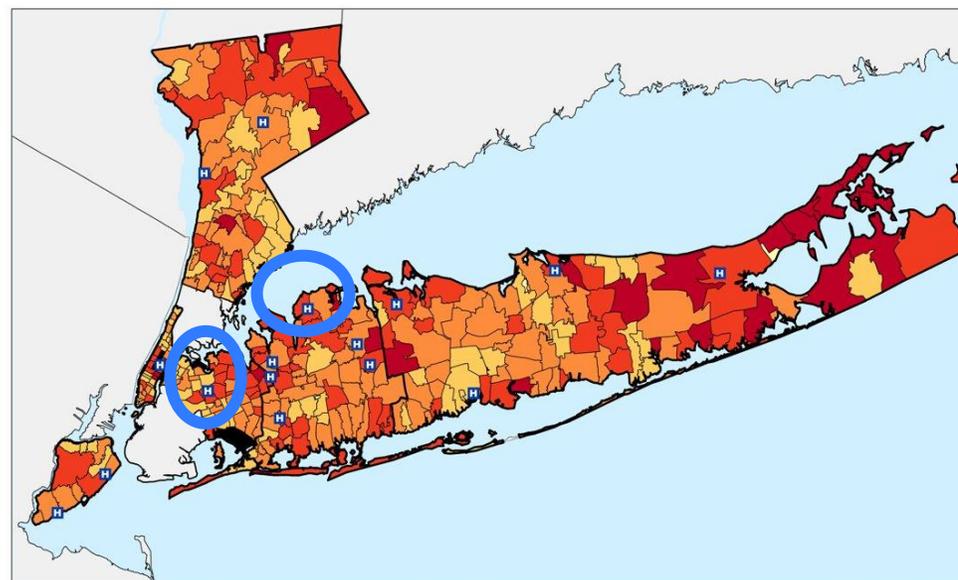
STEP 6: CHOOSE PILOT HOSPITALS

STEP 7: DASHBOARDS

STEP 6: IDENTIFY AGE-FRIENDLY PILOT HOSPITALS



- Health Care Organization
- Leadership Support
- Local Leadership Support
- Demographics
- Diverse population

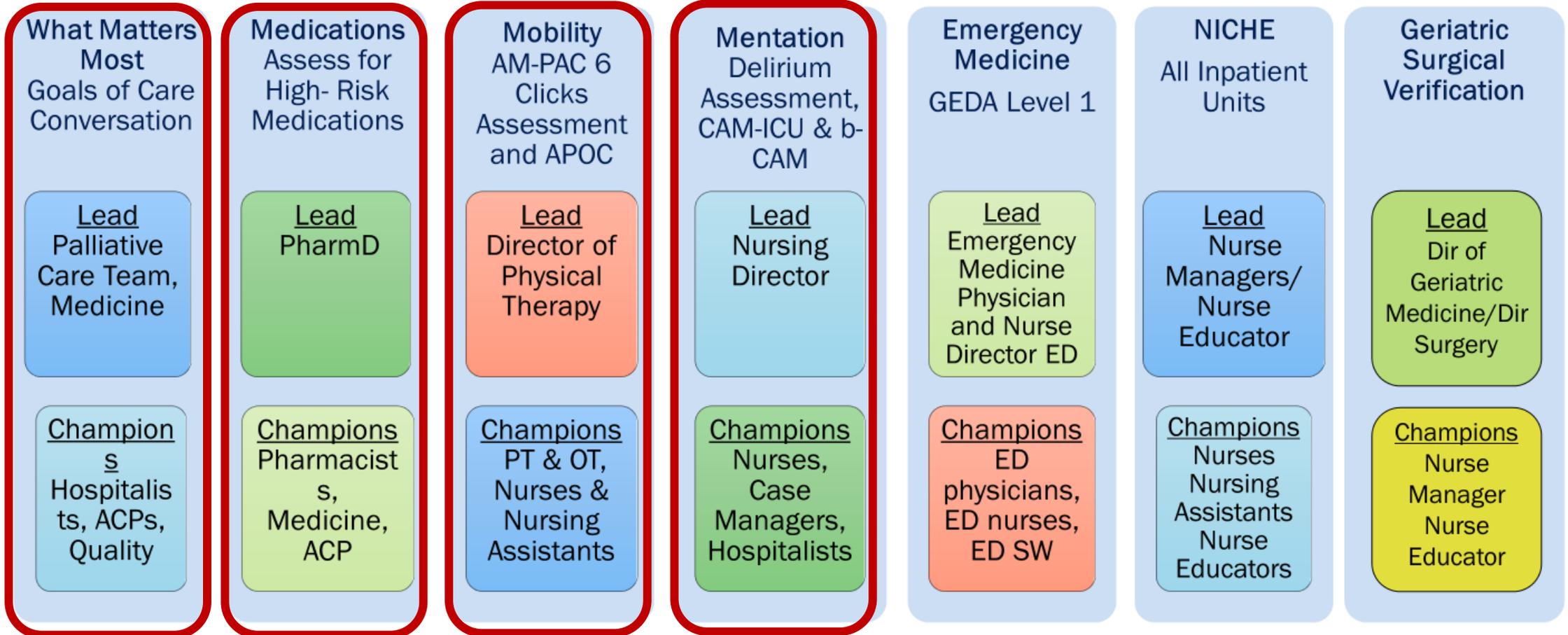


- Strong Ties to the Community
- Geriatrics and Palliative Physicians/ACPs

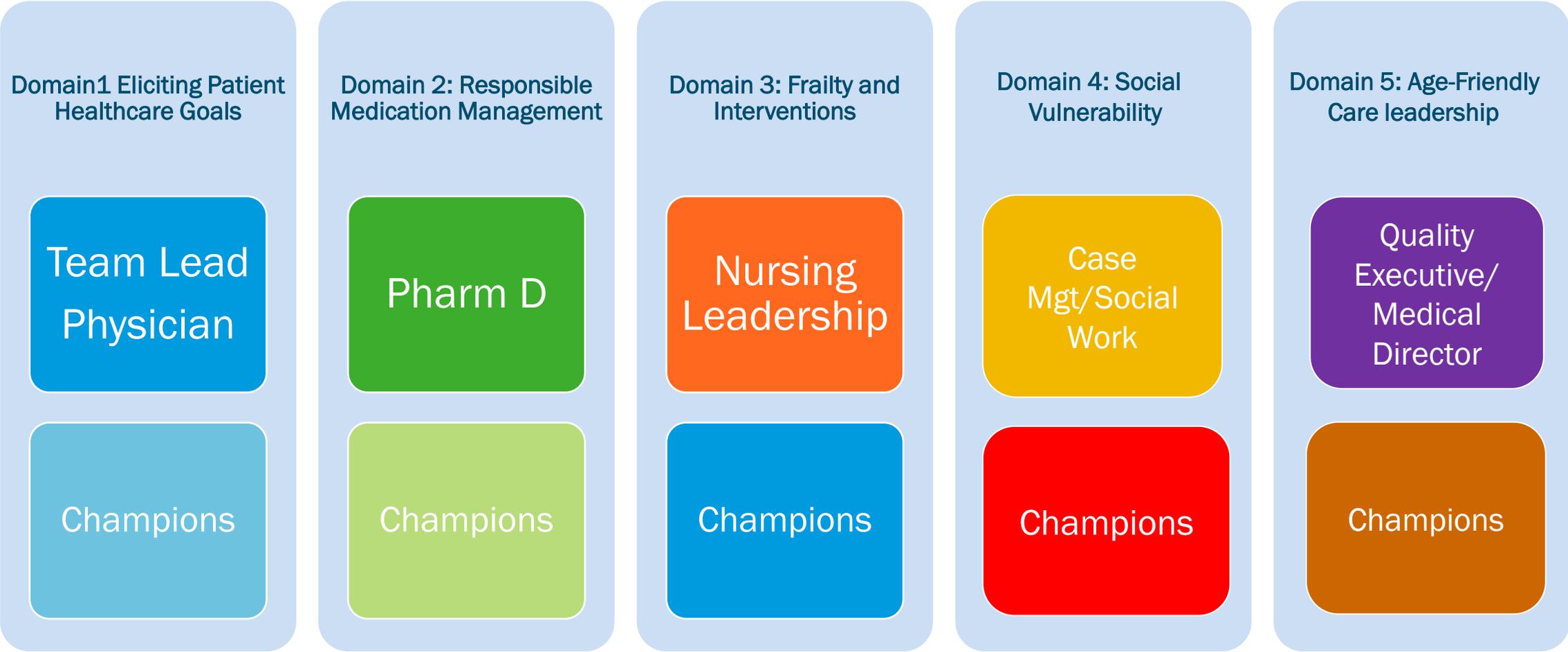
GLEN COVE HOSPITAL CENTER OF EXCELLENCE AFHS PICG

Steering Committee

Executive Director, Medical Director, Director of Geriatric Medicine, Nurse Executive, Associate Executive Director Quality Management



NEW EMERGING STRUCTURE



STEPWISE PROCESS TO AN AGE-FRIENDLY HEALTH SYSTEM

STEP 1: ASSESSMENT

STEP 2: RECOGNITION

STEP 3: STRATEGIC PLAN

STEP 4: PRACTICE STANDARDIZATION

STEP 5: METRICS

STEP 6: CHOOSE PILOT HOSPITALS

STEP 7: DASHBOARDS

DASHBOARD GOALS OF CARE CONVERSATIONS- ALL HOSPITALS



What Matters Most

GOC Conversations

Overview | **WhatMattersMost - GOC** | Mobility-AMPAC | Mentation-Delirium

Earliest Disch. Date:
 Latest Disch. Date:
 Facility:
 STAR Dx Category:

Data updated on 6/15/2025

Population: Inpatients with Age>=65 discharged after 2019
Overall Summary

Total Patients

Total Acute Patients: 53,811

*Excludes OB, Psych, Hospice and Rehab services

% of Patients with GOC Document

Total Patients: 29% (N=15,737)

Mortality (n=2,123)

No GOC: 16% | Has GOC: 84%

Location of First GOC Conversation

Emergency: 40%

(N=6,241)

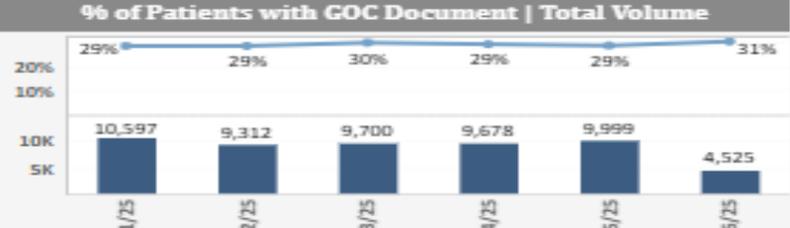


Inpatient: 60%

(N=9,496)

Trends based on discharge date
GOC Compliance and Time Measures
All GOC Note information is based off the first note written

% of Patients with GOC Document | Total Volume



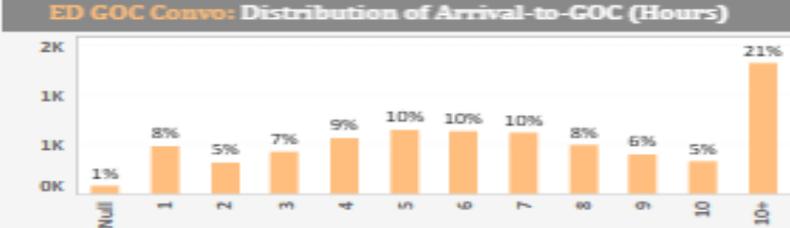
Date	% of Patients	Total Volume
1/25	29%	10,597
2/25	29%	9,312
3/25	30%	9,700
4/25	29%	9,678
5/25	29%	9,999
6/25	31%	4,525

ED GOC Convo: Volume and Avg. Arrival-to-GOC (Hours)



Date	Avg. Arrival (Hours)	Volume
1/25	10.2	1,313
2/25	9.3	1,152
3/25	8.5	1,184
4/25	7.0	1,032
5/25	7.4	1,037
6/25	7.1	523

ED GOC Convo: Distribution of Arrival-to-GOC (Hours)

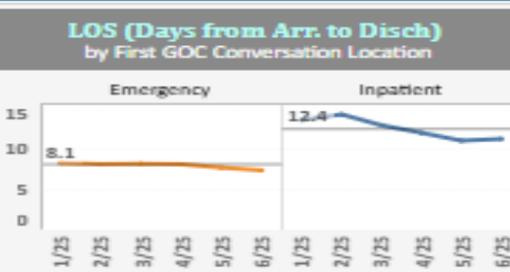


Hours	Percentage
Null	1%
1	8%
2	5%
3	7%
4	9%
5	10%
6	10%
7	10%
8	8%
9	6%
10	5%
10+	21%

Outcomes

LOS (Days from Arr. to Disch)

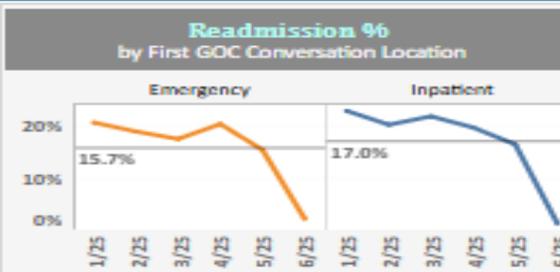
by First GOC Conversation Location



Location	LOS (Days)
Emergency	8.1
Inpatient	12.4

Readmission %

by First GOC Conversation Location



Location	Readmission %
Emergency	15.7%
Inpatient	17.0%

Age Group Distribution

Age Group	Total	% of Total	Total w/GOC Note	% w/GOC Note
65-74	20,623	38%	3,666	18%
75-84	19,814	37%	5,720	29%
85-94	11,477	21%	5,151	45%
>95	1,897	4%	1,200	63%

Lacey Score

(Patients w/ GOC)

Score	Total	% of Total
0-4	4,394	8%
5-9	15,725	29%
10-12	14,758	27%
>12	18,934	35%

Discharge Disposition (Top 5)

Disposition	Total	% of Total
Routine Discharge	5,503	35%
Skilled Nursing Facility	1,977	13%
Expired	1,788	11%
Hospice	868	6%
Inpatient Rehab Facil.	595	4%

June 23, 2025

DASHBOARD MOBILITY - ALL HOSPITALS

Overview | WhatMattersMost - GOC | **Mobility-AMPAC** | Mentation-Delirium



Mobility

AMPAC Screening: Critical Care

Earliest Disch. Date: Facility: Unit:
 Latest Disch. Date: Location: Data updated on 6/8/2025

Population: Inpatients with Age>=65 discharged after 2022

Overall Summary

Critical Care Patient Visits	% of Visits with Admit Compliance	% of Visits with Discharge Compliance	% of Visits with Full Visit Compliance
7,797 All Units	98% (7,627 of 7,797 Visits)	97% (7,529 of 7,797 Visits)	89% (6,957 of 7,797 Visits)

Scored Mobility Screenings: AMPAC (Mobility and ADL Assessments)

	Increase	No Change	Decrease
Mobility	2,558 (32.9%)	2,521 (32.4%)	2,607 (33.6%)
ADL Assessment	2,504 (32.2%)	2,336 (30.1%)	2,848 (36.7%)

AMPAC Screen & Compliance Measures

% of Visits w/ Admit Compliance & % of Visits w/ Discharge Compliance

Date	Admit Compliance (%)	Discharge Compliance (%)
1/25	97%	96%
2/25	97%	96%
3/25	98%	97%
4/25	98%	97%
5/25	99%	96%
6/25	99%	96%

% of Visits with Full Visit Compliance

Date	Full Visit Compliance (%)
1/25	87%
2/25	89%
3/25	89%
4/25	90%
5/25	91%
6/25	89%

% of Visits with Increased Score from Admit to Discharge

Date	Mobility (%)	ADL (%)
1/25	32%	30%
2/25	30%	30%
3/25	33%	33%
4/25	32%	33%
5/25	37%	35%
6/25	35%	33%

Patient Demographics (By Presence of AMPAC Screen)

Avg. Hospital LOS (Days) for Critical Care Visits

Date	Increase (Days)	No Change (Days)	Decrease (Days)
1/1	10.5	9.8	14.1
2/1	9.6	9.3	13.3
3/1	9.9	9.3	12.2
4/1	9.6	9.4	11.7
5/1	9.2	8.5	12.4
6/1	8.3	8.3	11.2

Discharge Disposition by Mobility Assessment Score Change

	Increase	No Change	Decrease
Routine Discharge/Home	1,144 (42%)	965 (35%)	625 (23%)
Home Care Services	568 (41%)	418 (30%)	410 (29%)
Skilled Nursing Facility	446 (35%)	329 (26%)	483 (38%)
Expired	43 (4%)	514 (42%)	604 (50%)
Rehab	169 (34%)	95 (19%)	235 (47%)
Hospice	31 (17%)	76 (42%)	72 (40%)
Transfer to another facility	42 (29%)	32 (22%)	66 (45%)

DASHBOARD MENTATION ALL HOSPITALS CRITICAL CARE

Overview | WhatMattersMost - GOC | Mobility-AMPAC | **Mentation-Delirium**



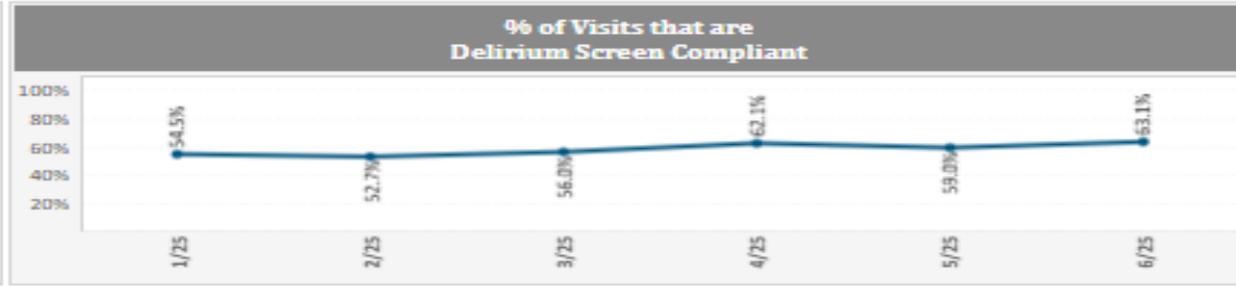
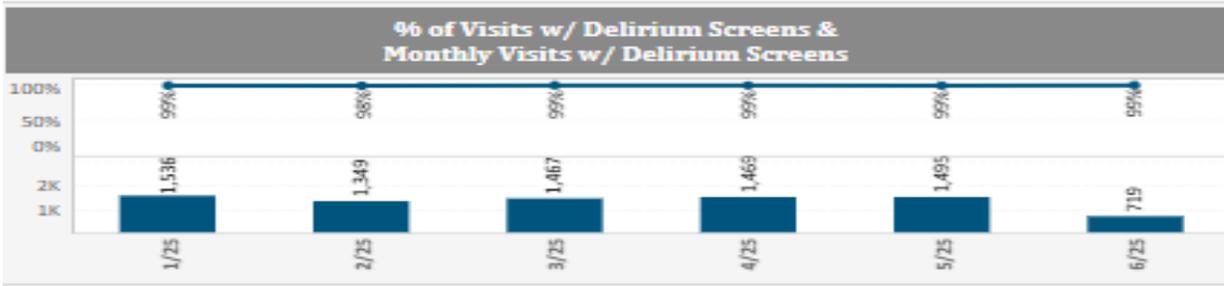
Mentation Delirium Screening: Critical Care

Earliest Disch. Date: 1/1/2025
 Facility: All Facilities
 Unit: (All)
 Latest Disch. Date: 6/14/2025
 Location: Critical Care
 Data updated on 6/15/2025

Population: Inpatients with Age >=65 discharged after 2019 | Overall Summary | Delirium Screenings: CAMICU & BCAM

Critical Care Patient Visits	% of Visits with a Delirium Screen	% of Visits with Screen Compliance	Critical Care Visits by Screen Result		
8,147 All Units	99% (8,035 of 8,147 Visits)	57% (4,681 of 8,147 Visits)	Positive 22% (N=1,783)	Negative 63% (N=5,100)	Only Unable to Assess 14% (N=1,152)

Delirium Screen & Compliance Measures



Patient Demographics (By Presence of Delirium Screen)



	Positive	Negative	Only Unable to Assess
Routine Discharge/Home	287 (10%)	2,369 (83%)	196 (7%)
Home Care Services	143 (10%)	1,065 (74%)	235 (16%)
Expired	575 (47%)	223 (18%)	436 (35%)
Skilled Nursing Facility	297 (35%)	469 (55%)	81 (10%)
Inpatient Rehab Facility	104 (24%)	255 (59%)	72 (17%)

DASHBOARDS MENTATION CRITICAL CARE- ALL HOSPITALS



Mentation

Delirium Screening: Non-Critical Care

Overview | WhatMattersMost - GOC | Mobility-AMPAC | **Mentation-Delirium**

Earliest Disch. Date:
 Latest Disch. Date:
 Facility:
 Location:
 Unit:
 Data updated on 6/15/2025

Population: Inpatients with Age >=65 discharged after 2019
Delirium Screenings: CAMICU & BCAM

Non-Critical Care Patient Visits

53,196

All Units

% of Visits with a Delirium Screen

89%

(47,533 of 53,196 Visits)

% of Visits with Screen Compliance

38%

(20,459 of 53,196 Visits)

Non-Critical Care Visits by Screen Result		
Positive	Negative	Only Unable to Assess
3%	94%	3%
(N=1,504)	(N=44,522)	(N=1,507)

Delirium Screen & Compliance Measures

% of Visits w/ Delirium Screens & Monthly Visits w/ Delirium Screens



Month	% of Visits w/ Delirium Screens	Monthly Visits w/ Delirium Screens
1/25	87%	9,155
2/25	88%	8,098
3/25	90%	8,625
4/25	90%	8,658
5/25	90%	8,935
6/25	91%	4,062

% of Visits that are Delirium Screen Compliant



Month	% of Visits that are Delirium Screen Compliant
1/25	31.7%
2/25	36.2%
3/25	39.3%
4/25	42.0%
5/25	42.4%
6/25	41.0%

Patient Demographics (By Presence of Delirium Screen)

Avg. Hospital LOS (Days) for Non-Critical Care Visits w/ a Delirium Screen

Screen Result:

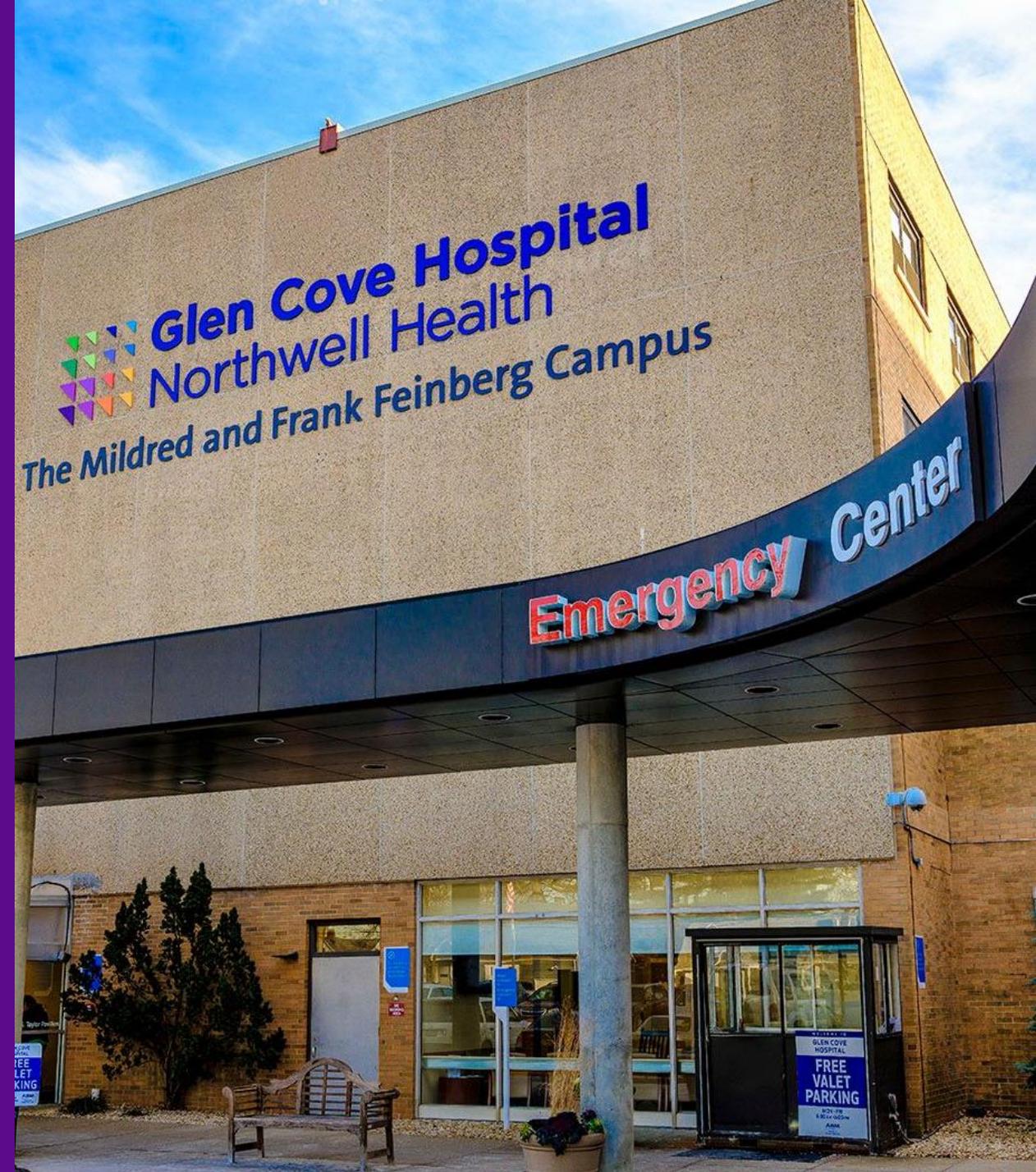


Month	POS (Avg. LOS)	UTA (Avg. LOS)	NEG (Avg. LOS)
1/25	16.3	13.9	5.9
2/25	16.3	13.3	5.7
3/25	12.4	12.4	5.7
4/25	14.8	11.5	5.5
5/25	12.4	12.4	5.4
6/25	12.2	12.2	5.4

Discharge Disposition by Screen Result

	Positive	Negative	Only Unable to Assess
Routine Discharge/Home	310 (1%)	23,261 (98%)	248 (1%)
Home Care Services	122 (1%)	8,295 (96%)	259 (3%)
Skilled Nursing Facility	277 (6%)	4,472 (92%)	126 (3%)
Expired	359 (20%)	901 (50%)	526 (29%)
Extended Care Skilled Nurs...	100 (6%)	1,547 (90%)	66 (4%)

Age-Friendly Health System in Practice: Glen Cove Hospital



GOALS OF CARE CONVERSATIONS – PILOT HOSPITAL

Overview | WhatMattersMost - GOC | Mobility-AMPAC | Mentation-Delirium



What Matters Most GOC Conversations

Earliest Disch. Date: 1/1/2025 | Latest Disch. Date: 6/14/2025 | Facility: Glen Cove Hospital | STAR Dx Category: All Patients

Data updated on 6/15/2025

Population: Inpatients with Age >=65 discharged after 2019 | Overall Summary

Total Patients

Total Acute Patients: 1,343

**Excludes OB, Psych, Hospice and Rehab services*

% of Patients with GOC Document

Total Patients: 65% (N=870)

Mortality (n=57)

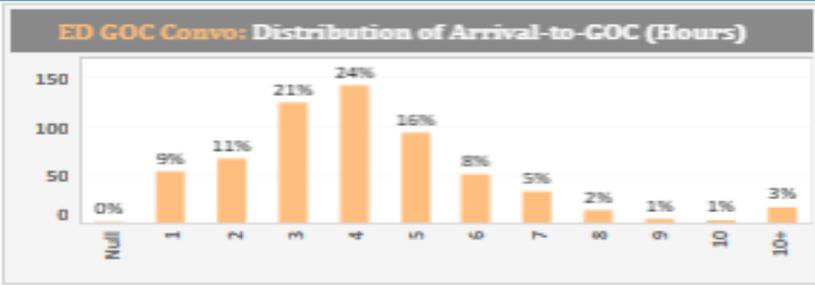
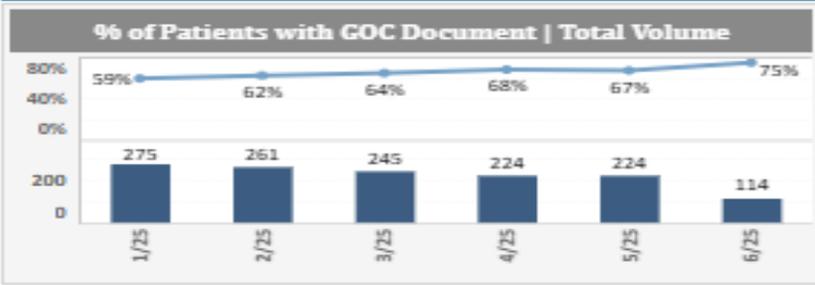
No GOC: 0% | Has GOC: 100%

Location of First GOC Conversation

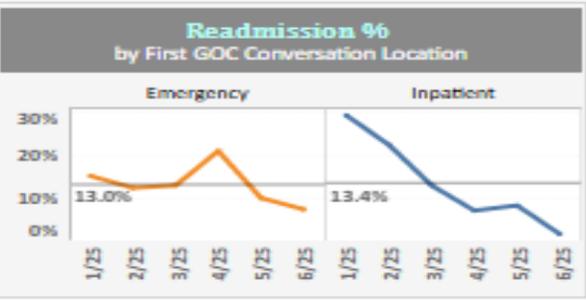
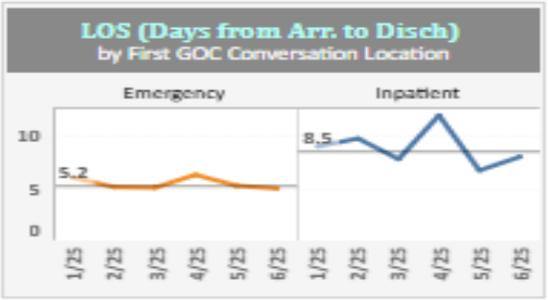
Inpatient: 31% (N=271)

Emergency: 69% (N=599)

Trends based on discharge date | GOC Compliance and Time Measures | All GOC Note information is based off the first note written



Outcomes | Clicking below will filter the dashboard population



Age Group Distribution

Age Group	Total	% of Total	Total w/GOC Note	% w/GOC Note
65-74	399	30%	186	47%
75-84	514	38%	341	66%
85-94	356	27%	279	78%
>95	74	6%	64	86%

Lace Score (Patients w/ GOC)

Score Range	Total	% of Total
0-4	23	(2%)
5-9	378	(28%)
10-12	413	(31%)
>12	529	(39%)

Discharge Disposition (Top 5)

Disposition	Total	% of Total
Routine Discharge	436	50%
Skilled Nursing Facility	148	17%
Expired	57	7%
Rehab Facility	42	5%
Acute General Hospit..	48	6%

MENTATION CRITICAL CARE PILOT HOSPITAL

Overview | WhatMattersMost - GOC | Mobility-AMPAC | Mentation-Delirium



Mentation Delirium Screening: Critical Care

Earliest Disch. Date: 1/1/2025
 Facility: Glen Cove Hospital
 Unit: GC CCU1
 Latest Disch. Date: 6/14/2025
 Location: Critical Care
 Data updated on 6/15/2025

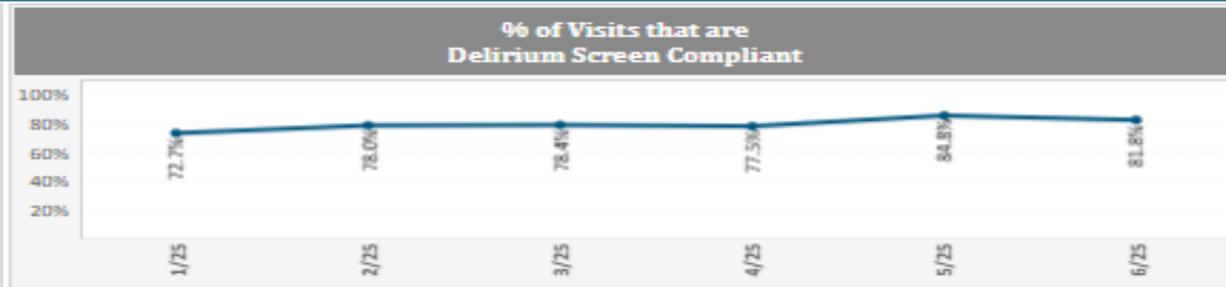
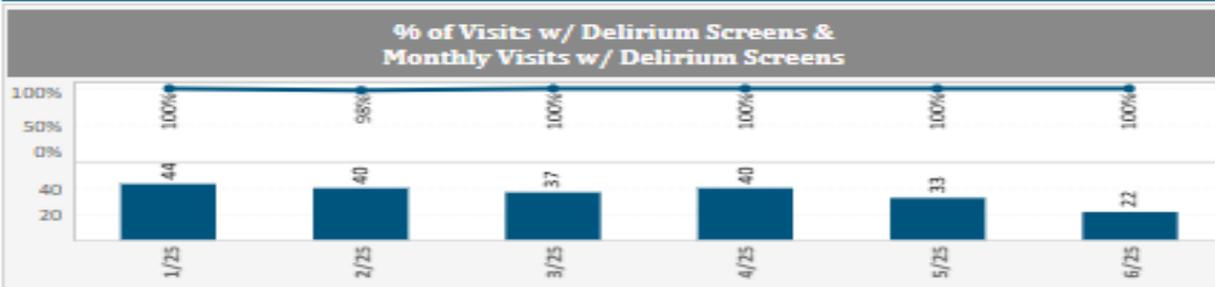
Population: Inpatients with Age>=65 discharged after 2019

Overall Summary

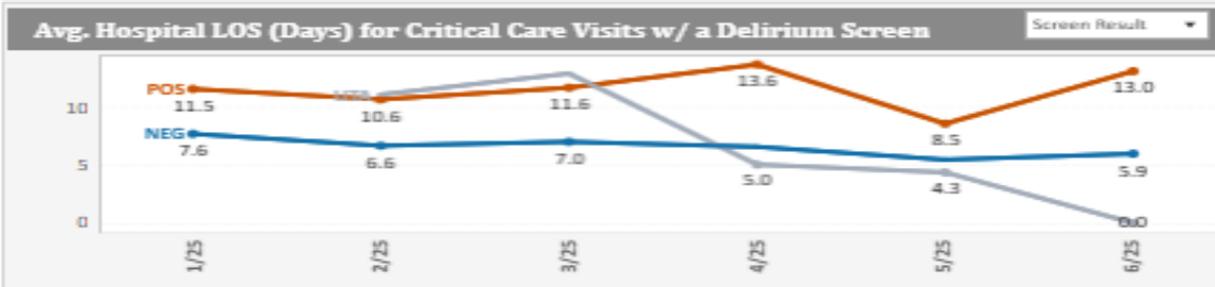
Delirium Screenings: CAMICU & BCAM

Critical Care Patient Visits	% of Visits with a Delirium Screen	% of Visits with Screen Compliance	Critical Care Visits by Screen Result		
217 GC CCU1	100% (216 of 217 Visits)	78% (170 of 217 Visits)	Positive 31% (N=68)	Negative 63% (N=136)	Only Unable to Assess 6% (N=12)

Delirium Screen & Compliance Measures



Patient Demographics (By Presence of Delirium Screen)



	Positive	Negative	Only Unable to Assess
Routine Discharge/Home	9 (12%)	63 (86%)	1 (1%)
Expired	19 (58%)	7 (21%)	7 (21%)
Skilled Nursing Facility	15 (45%)	18 (55%)	
Acute General Hospital	6 (25%)	18 (75%)	
Rehab	6 (46%)	7 (54%)	

MENTATION NON – CRITICAL CARE PILOT HOSPITAL

Overview | WhatMattersMost - GOC | Mobility-AMPAC | Mentation-Delirium



Mentation Delirium Screening: Non-Critical Care



Earliest Disch. Date:
 Facility:
 Unit:
 Latest Disch. Date:
 Location:
 Data updated on: 6/15/2025

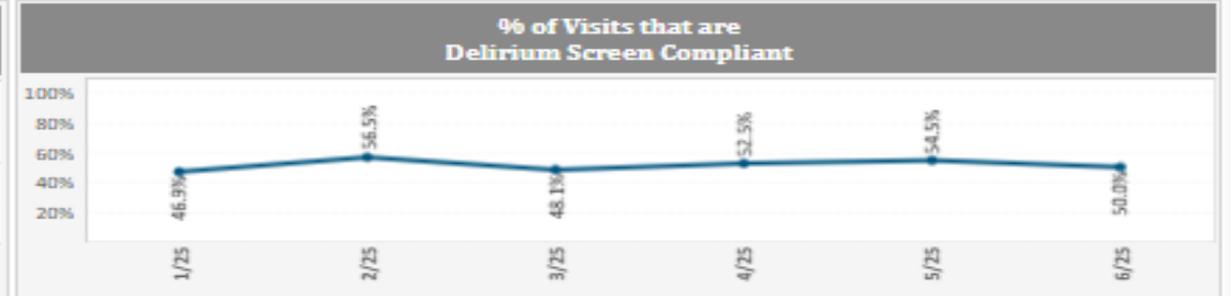
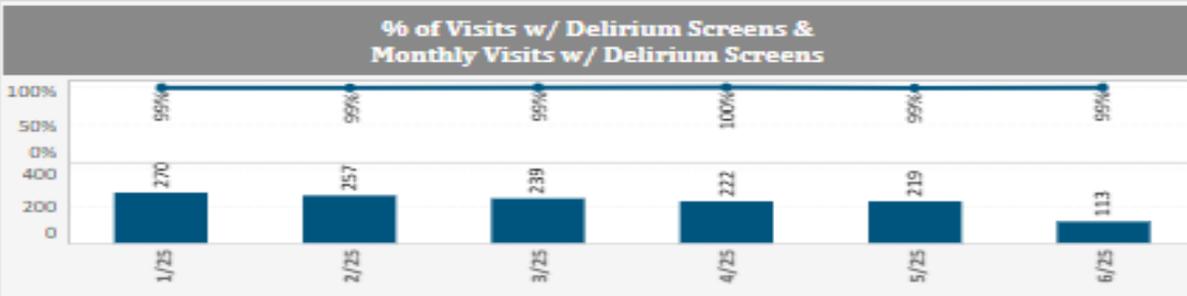
Population: Inpatients with Age>=65 discharged after 2019

Overall Summary

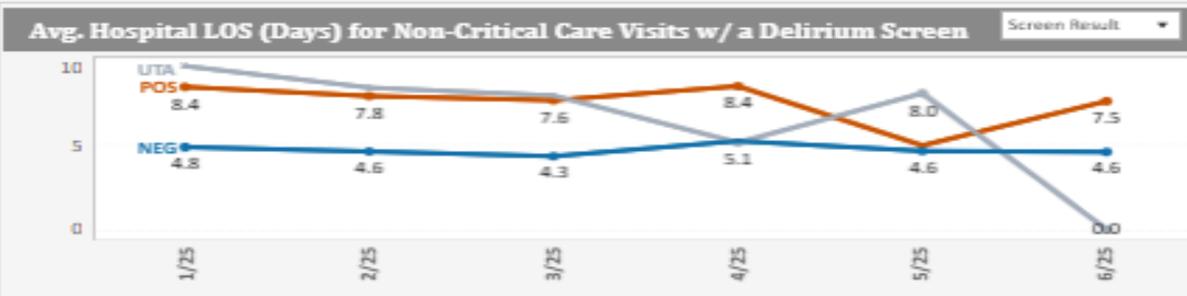
Delirium Screenings: CAMICU & BCAM

Non-Critical Care Patient Visits	% of Visits with a Delirium Screen	% of Visits with Screen Compliance	Non-Critical Care Visits by Screen Result		
1,333 All Units	99% (1,320 of 1,333 Visits)	51% (686 of 1,333 Visits)	Positive	Negative	Only Unable to Assess
			11% (N=143)	86% (N=1,139)	3% (N=38)

Delirium Screen & Compliance Measures

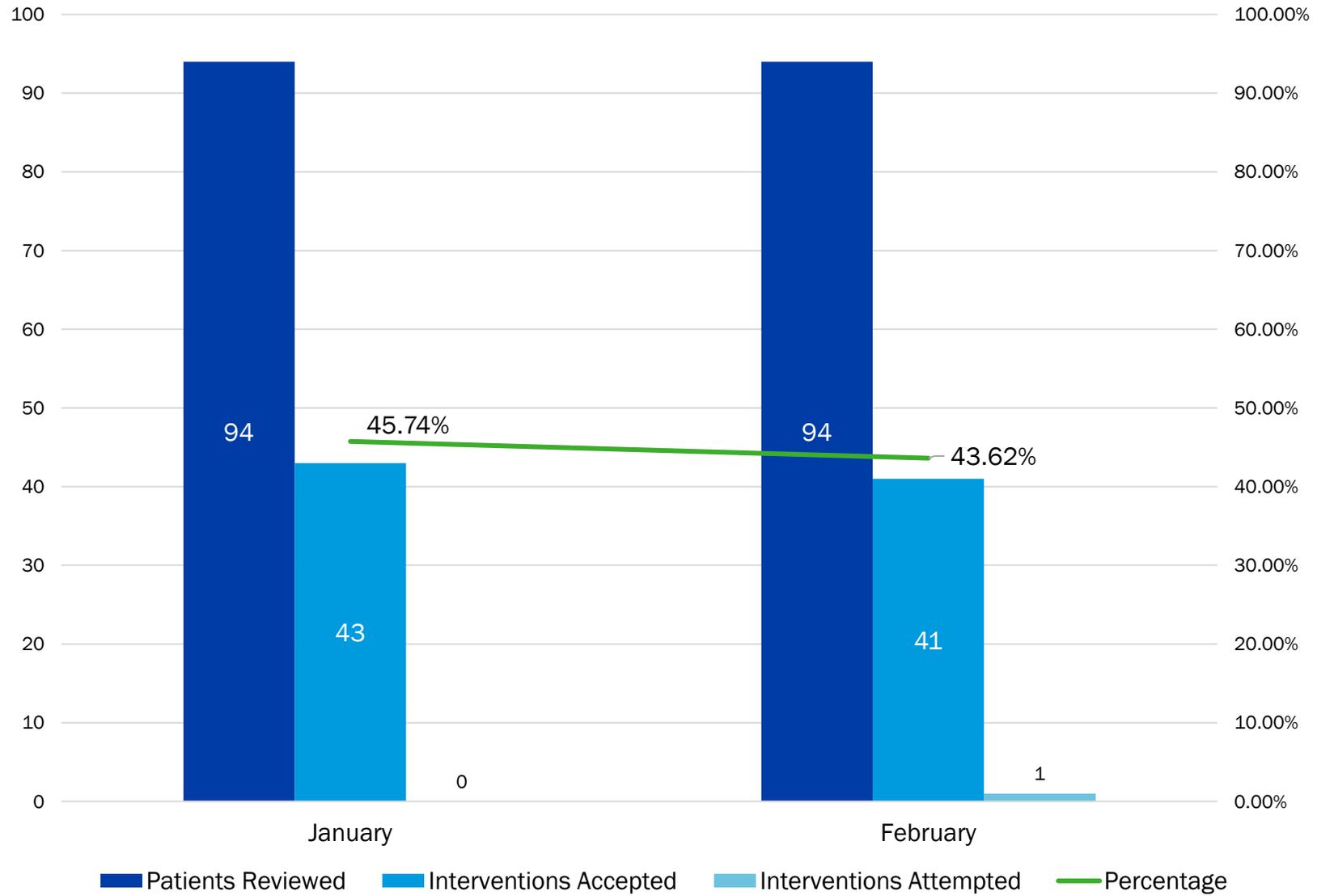


Patient Demographics (By Presence of Delirium Screen)

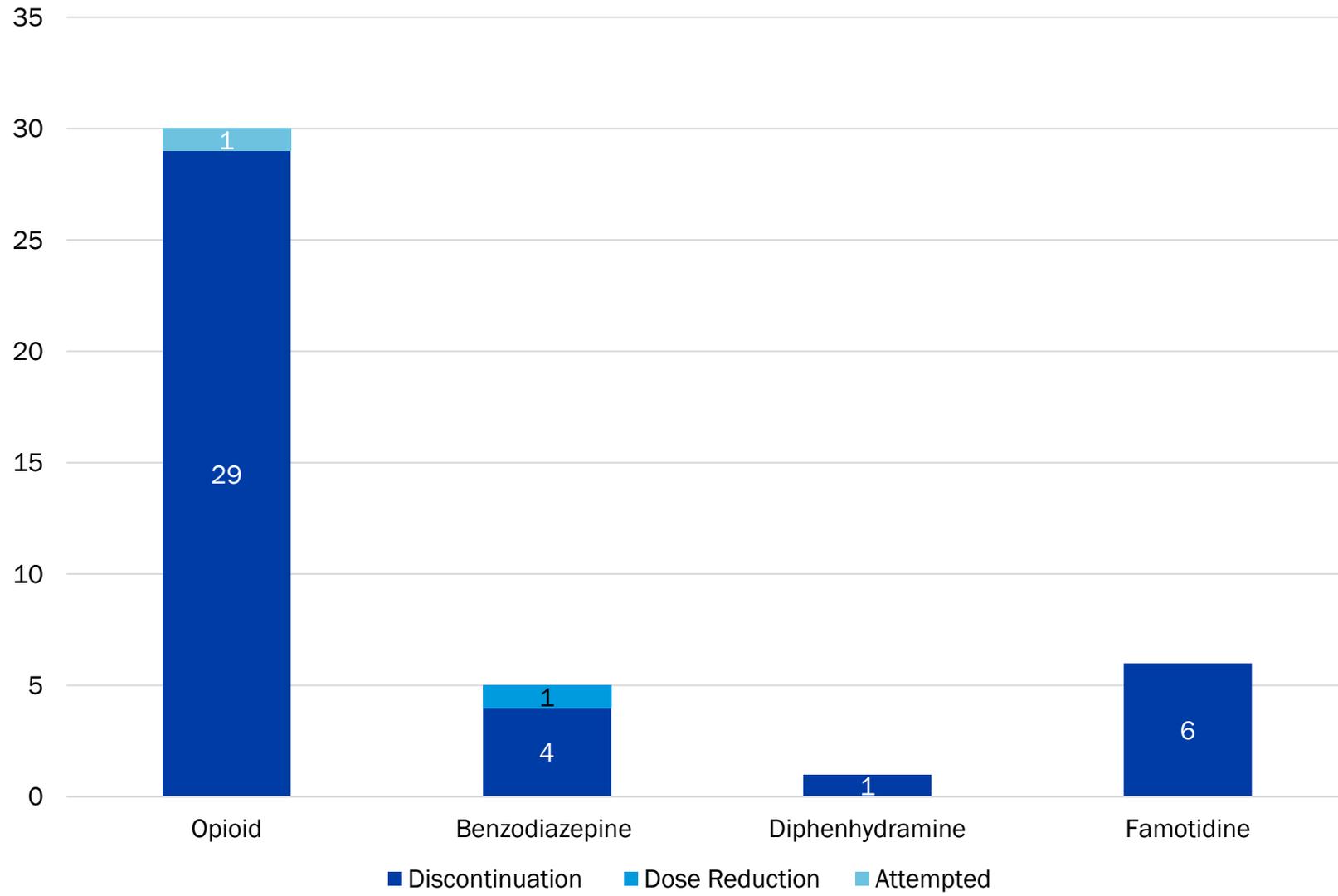


	Positive	Negative	Only Unable to Assess
Routine Discharge/Home	38 (5%)	678 (94%)	9 (1%)
Skilled Nursing Facility	33 (16%)	173 (83%)	3 (1%)
Acute General Hospital	7 (9%)	66 (86%)	4 (5%)
Rehab	9 (13%)	61 (87%)	
Expired	18 (34%)	22 (42%)	13 (25%)

2025 YTD Total Interventions



February 2025 - Interventions by Drug Class



PILOT SITE ACCOMPLISHMENTS

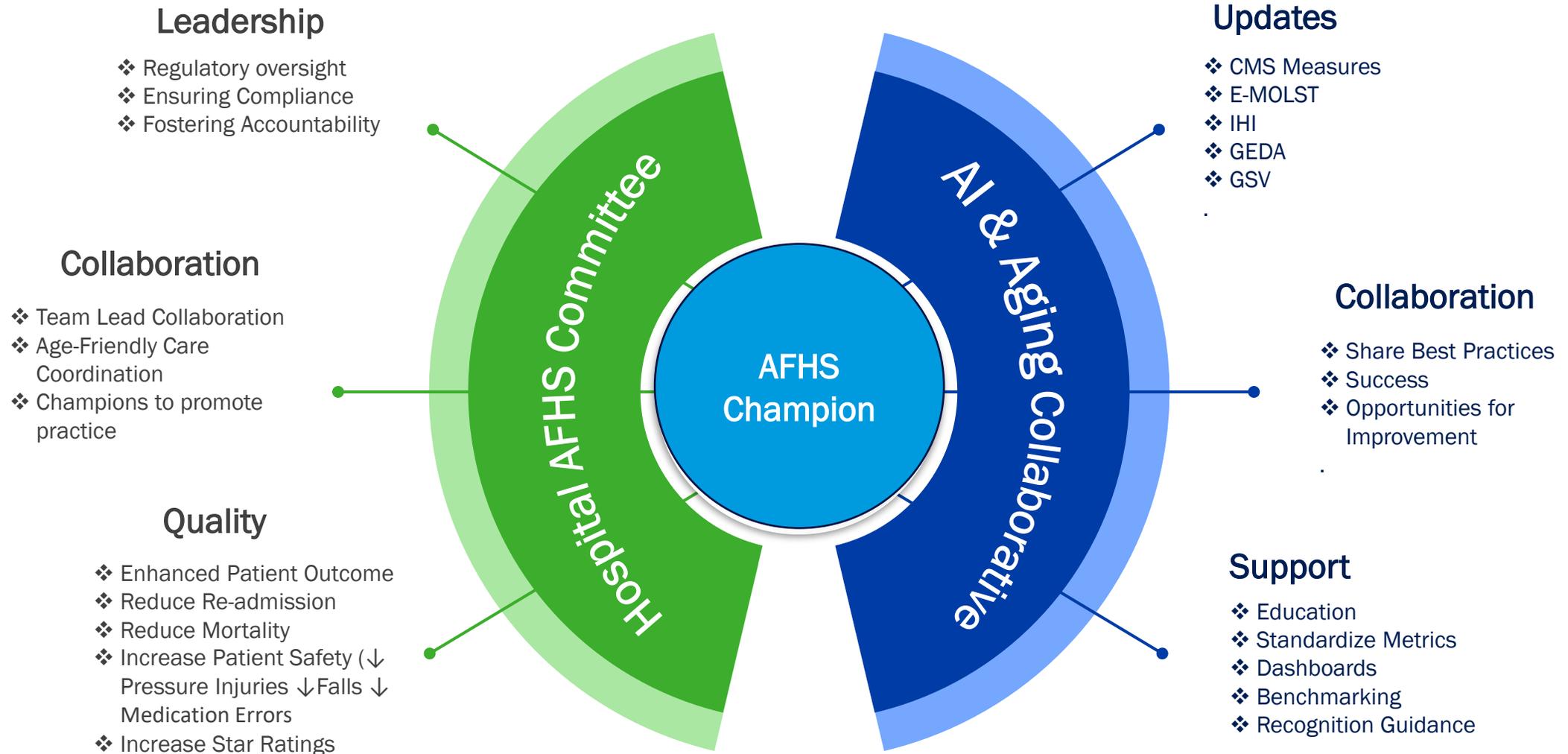
Glen Cove Hospital AFHS became the model to replicate

- Integrating the 4M Model into IDR
- Monthly Age Friendly PICG – sustainability and accountability

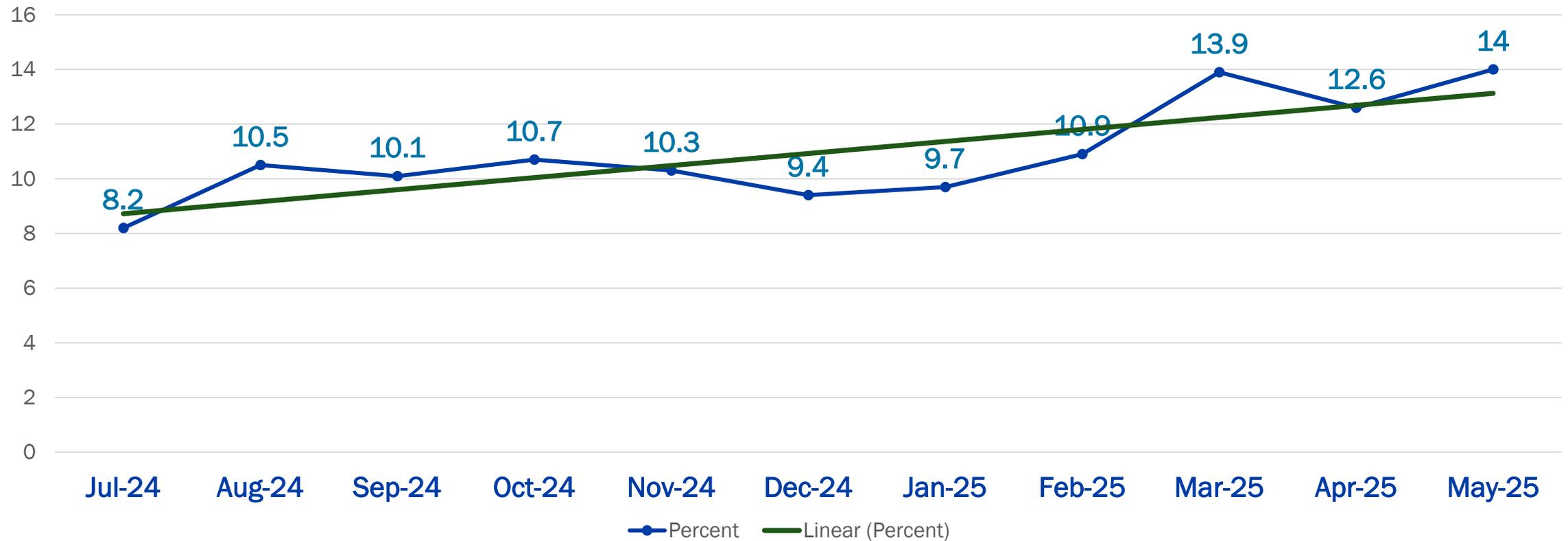
Since this work began in 2019 Glen Cove Hospital achieved:

- IHI Age Friendly Health System Committed Care to Excellence recognition
- NICHE
- Magnet designation
- ACEP Geriatric ED Level 1 accreditation
- Move from a 2 to a CMS 5 Star Rating 
- High Performing rank in USNWR Report for Geriatric Care

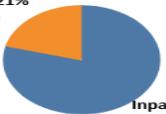
AI & AGING COLLABORATIVE & HOSPITAL AFHS COMMITTEE



PERCENT PATIENTS WITH ALL 4Ms ASSESSED



IMPACT SUMMARY – BY THE NUMBERS

Total Patients	% of Patients with GOC Document	Location of First GOC Conversation
Total Acute Patients: 96,378 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 15% (N=14,182) Mortality (n=6,369) No GOC: 49% Has GOC: 51%	Emergency: 21% (N=2,953)  Inpatient: 79% (N=11,229)
Total Acute Patients: 107,652 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 17% (N=18,237) Mortality (n=5,649) No GOC: 35% Has GOC: 65%	Emergency: 31% (N=5,638)  Inpatient: 69% (N=12,599)
Total Acute Patients: 109,766 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 21% (N=22,603) Mortality (n=4,973) No GOC: 28% Has GOC: 72%	Emergency: 32% (N=7,210)  Inpatient: 68% (N=15,393)
Total Acute Patients: 111,751 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 25% (N=27,650) Mortality (n=4,388) No GOC: 24% Has GOC: 76%	Emergency: 40% (N=10,925)  Inpatient: 60% (N=16,725)
Total Acute Patients: 115,738 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 27% (N=30,895) Mortality (n=4,446) No GOC: 19% Has GOC: 81%	Emergency: 41% (N=12,740)  Inpatient: 59% (N=18,155)
Total Acute Patients: 18,499 <i>*Excludes OB, Psych, Hospice and Rehab services</i>	Total Patients: 29% (N=5,305) Mortality (n=890) No GOC: 17% Has GOC: 83%	Emergency: 43% (N=2,276)  Inpatient: 57% (N=3,029)

2020

2021

2022

2023

2024

2025



OPERATIONAL EFFICIENCY & LOS

Length of Stay for Patients with Goals of Care Conversation in ED compared to after transition to IP.

There is an impact on LOS when early goals of care conversations occur in the Emergency Department.

LOS Analysis Top 3 DRGs by Location of GOC Jan-Dec 2024

DRG	Description	N (Number of Patients with ED Conversations)	LOS Inpatient Conversation	LOS ED Conversation	Savings
177	Respiratory Infections and Inflammation With MCC	501	9.4	8.5	135,270.00
177,178,179	Respiratory Infections & Inflammation With and without CC/MCC	574	9	8.4	103,320.00
DRG	Description	N (Number of Patients with ED Conversations)	LOS Inpatient Conversation	LOS ED Conversation	Savings
291	Heart Failure & Shock With MCC	814	9.5	8.5	244,200.00
291,292,293	Heart Failure & Shock With and without CC/MCC	830	9.5	8.5	249,000.00
DRG	Description	N (Number of Patients with ED Conversations)	LOS Inpatient Conversation	LOS ED Conversation	Savings
871	Septicemia or Severe Sepsis w/o MV>96 h With MCC	2268	11.4	9.6	1,224,720.00
871,872	Septicemia or Severe Sepsis w/o MV>96 h With and without CC/MCC	2440	11.2	9.3	1,390,800.00

Impact on Quality



Mortality

Readmissions

Safety

Patient Experience

4Ms

Star Rating Alignment

What Matters Conversation/Goal of Care Conversation/Goal Concordant Care (early hospice intervention, admission avoidance)

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Maintain Mobility
Assess, Prevent, Manage and treat delirium
Avoid/Minimize use of Potentially Harmful Medication

Incorporate All 4Ms into Patient Care
Incorporate All 4Ms into Interdisciplinary Rounds and Care Transitions

- ↓ Death rate for Heart Attack
- ↓ Death rate for CABG
- ↓ Death rate for Heart Failure
- ↓ Death rate for Stroke
- ↓ Readmissions for COPD
- ↓ Readmissions for Pneumonia
- ↓ Readmissions for Heart Failure
- ↓ Overall hospital-wide Readmissions
- ↓ Falls
- ↓ Serious Complications
- ↑ Communication with Doctors
- ↑ Communication with Nurses
- ↑ Communication About Medications

Transforming health care: A large health organizations' journey to become an age-friendly health system (AFHS) and beyond

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Abstract

Background: In 2017, the John A. Hartford Foundation partnered with the Institute for Health Care Improvement, American Hospital Association, and Catholic Health Care Organization to define the 4Ms framework to improve quality of care and health outcomes for older adults. The senior leadership of one of the largest integrated healthcare organizations (HCO) in the country recognized the relevance of these recommendations to the aging demographic of the United States. The health system provides care to over 2,000,000 unique patients annually, about 20% of whom are aged ≥ 65 . We describe how commitment to becoming an Age-Friendly Health System (AFHS) has taken this HCO beyond the targets set by the initiative.

Methods: Steps guiding evolution of the AFHS model of care are as follows: Initiation, assessment, planning, implementation, sustainability. An AFHS leadership team including geriatrics and quality improvement expertise oversees the initiative. Plan-Do-Study-Act cycles are utilized at multiple stages to develop structures for data collection and reporting outcomes.

Results: Initiation and assessment stages identified key champions and existing efforts and programs that were leveraged to implement 4Ms best practices. Working committees with relevant expertise for each M selected evidence-based quality measures and designed/adapted training materials. The EHR is used to integrate quality measures and gather outcome data to inform changes in care. Dashboards capturing quality measures for each M have been implemented and pilot-tested at a community-based hospital and these processes are being adapted and disseminated to other settings. Leadership and stakeholders convene regularly to review lessons learned and next steps.

Conclusions: On the health system level, partnering with quality management leaders has led to development of processes that feed into organizational level data used to track longitudinal improvements in patient outcomes. Outcome data in each of the 4M domains are presented. Learning points are shared to help others take a systems-approach to age-friendly change.

THANK YOU