

**GERIATRIC SERVICES  
CAPACITY ASSESSMENT**

**DOMAIN 1 - RELATIONAL-  
BASED CARE MANAGEMENT**

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# INTRODUCTION

## Purpose

The Geriatric Services Capacity Assessment was developed to help health plans and health systems, including community providers, hospitals, and other health care delivery organizations, evaluate their current ability to meet the needs of geriatric adults and to identify strategic opportunities for improvement.

*Geriatric-competent care focuses on providing care and support for maximum function and prevents or eliminates barriers to integrated, accessible care.*

## Serving Senior Medicare-Medicaid Enrollees

Medicaid provides health coverage to more than 4.6 million low-income seniors, nearly all of whom are also enrolled in Medicare. Medicaid also provides coverage to 3.7 million people with disabilities who are enrolled in Medicare. In total, 8.3 million people are enrolled in both Medicaid and Medicare, which accounts for more than 17 percent of all Medicaid enrollees. Many of these beneficiaries have complex care needs; they have a significant impairment in physical functioning (some difficulty with two or more activities of daily living) and/or severe impairment in cognitive functioning. Health organizations must adapt to adequately meet the needs of this growing vulnerable population.

### *Medicare-Medicaid Enrollee Population*

- *59 percent are elderly*
- *Compared to other Medicare beneficiaries, Medicare-Medicaid enrollees have:*
  - *More chronic conditions*
  - *More cognitive and other functional limitations*
  - *Lower income*

## How to Use This Tool

Inherent in geriatric-competent care is the need to engage the individual in defining their care goals and needs. Establishing geriatric-competent care within a health plan or health system affects all functional areas of the plan or system, from direct care delivery to contract and payment modifications to management systems to the inclusion of a full range of home- and community-based care options and supports. As such, all key functional areas in the organization should be represented in the completion of the Tool.

# 1 RELATIONAL-BASED CARE MANAGEMENT

Relational-based care recognizes that the consumer is not merely a passive recipient of medical care, but rather the primary source for defining care goals and needs.<sup>1</sup> This type of care requires cultivating a relationship with the consumer, seeing him or her as a whole person with hopes and preferences, and recognizing that the consumer is often the best steward of resources. Inherent in consumer-centered planning of care goals and needs is also the concept of dignity of risk, which respects the consumer's choices even if they are inconsistent with the recommendation of the interdisciplinary team (IDT). You are encouraged to return to this domain frequently to guide your understanding of the other seven domains.

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<sup>1</sup> The term consumer is used in this Tool in place of patient, member, or participant, acknowledging the individual's agency in decisions and interactions.

## 1.1 Consumer-Centered Practice

The consumer's choices, preferences, and goals provide a foundation for his or her individualized and person-centered plan of care (IPC). The IPC identifies all the care, services, and supports for each consumer. It is a dynamic document, referenced, reviewed, and revised over time, to ensure preventive strategies are in place, and that plans are effective, are being followed, and are based on the consumer's changing needs. A trusting and respectful relationship between the consumer and his or her care team is necessary to ensure decisions for care and services remain consumer-centered.

### 1.1.1 Do consumers play an active role in their own assessment and care planning?

Consumers commonly need support and coaching about the assessment and care planning process. This support is provided by individuals, including physicians, nurse practitioners, physician's assistants, case managers, home and community based services (HCBS) providers, staff at alternate living arrangement facilities, and others, who are familiar with the assessment and care planning process and understand how it may be daunting and overwhelming. A preliminary "get to know you" meeting can help establish the relationship so that the subsequent meeting can focus on the full assessment and care plan development.

### 1.1.2 Does staff develop an individualized, professional relationship with the consumer, showing respect for the consumer's preferences and for the dignity of risk?

Developing this trusting relationship generally requires an initial face-to-face interaction and includes discussion of the consumer's goals, values, and preferences for his or her care. This relationship is paced so the consumer, family and clinicians have time to evaluate thoroughly the consumer's needs.

### 1.1.3 Are older consumers (and families or caregivers) involved in care planning and implementation to ensure a consumer-centered focus?

Organizations with geriatric competency involve the consumer throughout the care planning process and in each step of creating and updating the individualized care plan. Health plans and systems that provide geriatric-competent care have multiple avenues to engage older consumers in care planning and to seek their perspectives and ideas. Consumers provide one of the best sources for performance feedback. They should be asked to periodically provide feedback on their experience of care planning and implementation as well as about the providers of their care. Organizations may need to involve families or caregivers more closely in the care planning process when providing care to consumers with certain conditions (e.g., Alzheimer's disease). Family members and caregivers can help in the recall and understanding of the complete array of symptoms and can ensure appropriate follow-up, either with health professionals or with other resources available in their community. Refer to **Domain 5 - Caregiving** for more information on working with informal caregivers in the care planning process.

### **1.1.4 Does staff consistently respect and accept the decisions and preferences of consumers?**

A consumer may have difficulty identifying or asserting his or her preferences, so the IDT will want to consistently seek his or her perspective and preferences. If a consumer's preference is inconsistent with the IDT's recommendation, the consumer's choice needs to be respected. The IDT will want to discuss the pros and cons of the consumer's preference while advocating for recommended options. It is also important to know when to stop advocating for recommended options so that the consumer does not feel unduly pressured every time he/she seeks care. If the consumer is ambivalent or requests guidance, shared decision-making and decision support should be offered. For consumers with certain conditions (e.g., Alzheimer's disease), it can be difficult to ensure that the consumer understands important information regarding his or her care in order to make an informed decision. This reinforces the need to involve both the consumer and close family members or caregivers at all stages of the care process so that the consumer's wishes can be balanced against the needs of the family, caregiver, and other social supports.

### **1.1.5 Does the IDT periodically assess how well each consumer understands his or her rights and consumer protections?**

Geriatric-competent organizations routinely include this assessment as part of the initial assessment and all reassessments. Staff are trained to be sensitive to any resistance or concerns expressed by the consumers and to remind them of their rights to disagree. The presence of pain, depression, acute illness or hearing loss poses particular challenges to consumer engagement, self-advocacy and decision-making. Geriatric-competent organizations assess for these conditions and enhance consumer support. For consumers with certain conditions (e.g., Alzheimer's disease), pain may manifest itself in different ways, including agitation or other behavior changes, which may further complicate decision-making.

## 1.2 Eliminating Medical and Institutional Bias

Medical and institutional bias often impedes providers from addressing the whole individual, including his or her unique abilities, limitations, and preferences for social and community participation. Social and community participation may require supports and services for the older consumer to remain in his or her preferred living setting. Care planning needs to consider the right amount of care (not too much, not too little) as well as the right location (least intensive and least restrictive).

### 1.2.1 Does the IDT help consumers explore all possible options for living in the least restrictive environment of their choice?

When the consumer and his or her IDT determine that the consumer's current residential setting is unable to meet his or her needs, the care team identifies and discusses a range of options with the consumer and the family or caregiver, as appropriate. Since care is usually attached to the residential setting, it is important to offer as wide a choice as possible. It is important, as well as mandated, to offer as wide a choice of living arrangements as possible. It is important to consider locations in choice so that long-time friends and family can easily visit.

### 1.2.2 Are consumers given a choice of community supports and service providers?

Older consumers may want to understand their options for community-based support, including informal supports rather than paid workers. They may also need education on self-directed models for community supports or a traditional agency/provider model, as well as options for maintaining existing personal care assistant (PCA) relationships. (See 3.2 in **Domain 3 - Comprehensive Long Term Supports and Services** for further information). Additionally, having access to a roster of service and support providers with an evaluation of provider performance will support, foster, and enable consumer choice.

### 1.2.3 Is the consumer's current living situation re-evaluated prior to planning a permanent transition to a greater level of care?

Many organizations with geriatric competence establish a re-evaluation process that includes considering if adaptations or additional supports could enable the consumer to continue living in his or her current setting. This process seeks to ensure that permanent changes are a choice of last resort.

### 1.2.4 Are potential ethical conflicts formally reviewed via committee or consultation to ensure consumer autonomy and self-determination?

The aging process has the potential to constitute a significant threat to autonomy as older adults often need to rely on others when faced with functional, emotional or cognitive impairment. Therefore, it is imperative that organizations with geriatric capacity have formal protections in place to ensure that potential ethical conflicts are identified, assessed, and addressed.

## 1.3 Interdisciplinary Team

Geriatric-competent care is interdisciplinary team-based care with core competencies in primary care, behavioral health, geriatrics, Long-term Services and Supports, and gerontological nursing. Operating in close communication with the consumer and external providers, the interdisciplinary team (IDT) is responsible for ensuring the consumer receives the care and supports he or she needs to achieve his or her goals and maximize independence.

### 1.3.1 Composition

#### *1.3.1.1 Are the competencies of primary care, nursing, behavioral health, and LTSS represented on each IDT?*

The core care team is comprised of staff with competencies in primary care, nursing, behavioral health, and community-based service supports. Primary care practitioners might include physicians, nurse practitioners, or physician assistants. Nursing practitioners might include advanced practice nurses, registered nurses, or licensed practical nurses. Behavioral health practitioners might include social workers, psychologists, chemical dependency specialists, or other comparably trained practitioners. LTSS practitioners might include social workers, mental health therapists, community health workers, or other comparably trained care management staff. Special training in geriatric medicine, gerontological nursing, social work or related disciplines is essential to providing skillful assessment and care and, ideally, one or more members of the team should be credentialed in geriatrics or gerontology (e.g., geriatrician, gerontological advanced practice nurse, geriatric social worker or geriatric care manager). Team care is essential to provide optimal support to the older consumer. No one person has all the information or skill to assess the consumer in a holistic manner or ensure the right care is provided.

#### *1.3.1.2 Are practitioners on the IDT experienced in providing disability-competent care since so many aging persons are also disabled to some degree?*

All members of the IDT should either be experienced in working with older adults who also may have a disability or, at a minimum, willing to be trained and coached accordingly. Organizations with geriatric capacity should have extensive training programs for new staff to teach disability sensitivity, awareness, and considerations related to their specific area of practice, including core concepts of geriatric and gerontological practice.

#### *1.3.1.3 Is the consumer's primary language, means of communicating, and ethnic/cultural competencies considered in identifying specific members of the IDT?*

While this is not always feasible, having IDT members with these competencies can increase the trust between the consumer and his or her IDT. Assistive technologies and methods to communicate with persons who have expressive or receptive communication challenges should also be considered.

#### ***1.3.1.4 Do all IDT members understand their individual roles and responsibilities?***

While the IDT collectively shares responsibility for the health and well-being of each consumer, each member of the IDT practices within his or her scope of competency, minimizing redundancy and utilizing support staff when appropriate.

#### ***1.3.1.5 Is one member of each consumer's IDT designated as the "lead"?***

It is imperative that one team member have final responsibility and accountability for both the IDT and the IPC. Some organizations choose to routinely have the team lead assigned to a specific role (such as the primary care practitioner), while others use a specified collaborative practice model or choose to vary the designation of lead based on the unique needs and/or preferences of the consumer.

#### ***1.3.1.6 Are additional resources or consultants available to the IDT based on the specific needs of each consumer?***

Additional resources or consultants may include sub-specialty (dental, podiatry, pain management) providers, rehabilitation (OT, PT, speech therapy, etc.), durable medical equipment, nutritional services, and pharmacy.

#### ***1.3.1.7 Is the consumer able to designate a family member or close friend to be involved in IDT-related communications?***

When a consumer specifies a family member or other person to be involved in IDT communications, this must be documented in the IPC and communicated to all IDT members to ensure consistent follow-through.

### **1.3.2 Communications**

#### ***1.3.2.1 Does the IDT meet weekly to discuss relevant consumer updates, new assessments, and reassessment reviews?***

Many organizations use structured agendas to ensure the productive use of team meeting time. Meetings can be in-person or virtual. While not every consumer is discussed every week, it is helpful to have system triggers in place to ensure: 1) review of any consumer under acute care, 2) review of any consumer transitioning from one facility to another setting of care whether that is another facility or back into the community residence, 3) discussion of any change in health or caregiver status, and 4) routine, prescheduled reviews.

#### ***1.3.2.2 Does the IDT ensure that each consumer's IPC is reviewed at predetermined intervals?***

Each consumer should have his or her IPC reviewed at regular intervals (bi-annually, at a minimum), as well as when a new issue or change in condition emerges.

**1.3.2.3** *If a consumer maintains a relationship with an external care provider, (a provider outside of the IDT) is there a designated staff member who is the point of contact for the external provider?*

Some older consumers may choose to maintain relationships with other care providers who are not actively involved in the consumer's care. If this is the situation, the lead on the IDT is often designated to be responsible for communicating with the external care provider.

**1.3.2.4** *Is the IDT able to meet, either in person or virtually, within 24 to 48 hours if the consumer's needs or situation changes?*

The need for timeliness will vary depending on the urgency of the situation. In some organizations, IDT members maintain flexible schedules to be able to address emerging concerns.

**1.3.2.5** *Is the assessment and IPC available to anyone providing after-hours coverage?*

At a minimum, information on each consumer's IPC should be available via fax or encrypted or secure email, but is ideally in the form of a remotely accessible electronic health record (EHR). See section 1.4 for a full description of the assessment(s).

## 1.4 Assessment

The initial and regularly revised assessment of the consumer's care needs and goals is an interactive process, with the outcome being a comprehensive IPC. The initial assessment provides a key opportunity for the IDT to establish a relationship with each consumer and to build the trust needed for successful, ongoing care and care management.

### 1.4.1 Is the initial assessment conducted in-person?

Geriatric-competent organizations have found that a key lever to establishing a trusting and respectful relationship between the older consumer and his or her IDT is having the opportunity to meet in person. If an in-person meeting is not possible, video or telephone conversations may be used until the consumer is able to have an in-person meeting.

### 1.4.2 Are at least a portion of the initial assessment and the periodic reassessments conducted in the consumer's living environment?

Organizations with geriatric competency have found that meeting in the older consumer's living environment often helps overcome barriers to care, including transportation and functional limitations. This also provides the IDT an opportunity to see first-hand where the consumer lives, assess his or her level of function within the home environment, and identify opportunities to increase independence and safety in daily functioning. Some consumers may opt to initially meet their IDT in a venue outside the home. If this is the case, the IDT should work to gain the trust of the consumer so they can be welcomed into the consumer's home to see how he or she functions in this environment.

### 1.4.3 Are the initial and subsequent assessments attended by all members of the core IDT (see 1.3.1)?

It is important for all members of the consumer's IDT to actively participate in the assessment process, for each team member brings a different set of skills and knowledge.

### 1.4.4 Is the consumer able to include other individuals in the assessment process?

The consumer may wish to include other individuals such as family members, caregivers, friends, community supports, ministers, ombudsmen, care managers and clinicians such as nutritionists.

### 1.4.5 Does the assessment process identify additional expertise needed for the consumer's care?

The IDT should incorporate the expertise of other clinicians or care providers as needed, including rehabilitation therapists, behavioral health providers, dieticians, peers, LTSS providers, or specialists (such as geriatricians, gerontological clinical nurse specialists and palliative care practitioners), either on an ongoing or consulting basis.

### 1.4.6 Is the initial assessment comprehensive and multidimensional, incorporating all aspects of the consumer's life?

Domains to be assessed include:

- Advanced health care decision-making and advanced directives
- Cognitive and behavioral health screening, diagnoses, and history (including screening for Alzheimer's disease)<sup>2</sup>
- Community participation, employment, and volunteer status
- Consumer strengths, goals, values and priorities
- Demographic, contact, financial, and eligibility information
- Financial benefits and entitlements and financial and/or legal challenges
- Formal, informal, and social supports
- Functional assessment (activities of daily living [ADL], instrumental activities of daily living [IADL])
- Health-related services (including behavioral management, exercises, equipment use, skilled therapies, rehabilitation therapies) and all current providers
- Home and community environment, safety, accessibility, and health risks
- Long-term services and supports use and all current vendors
- Medical screening, diagnoses, and history
- Medication management practices
- Medications (including prescription, over-the-counter, herbal or naturopathic remedies and recently discontinued medicines)
- Nutrition (food access, preparation, diet, etc.)
- Preferred providers for acute care, post-acute care and pharmacy
- Self-care practices
- Social activities, roles, and important relationships to people, animals, places and possessions

The IDT should be alert for under-reporting of conditions due to incorrect beliefs that they represent normal aging, embarrassment, or fear of clinician response. These may include conditions such as depression, sleep disturbance, pain, incontinence, change in sexual function, memory loss, falls, constipation, excessive fatigue, driving mishaps, or risky use of alcohol, prescription or non-prescription drugs. IDT members should receive training in culturally appropriate methods to assess these conditions.

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<sup>2</sup> Basic cognitive assessment tools include the Mini-Cog, Memory Impairment Screen (MIS), or GPCOG Screening Test. More information on cognitive assessment tools can be found here: <http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp#patientassesstools>

## 1.5 Individualized and Person-Centered Plan of Care

The IPC is the guiding document that identifies all the care, services, and supports for each consumer. It is a dynamic document, referenced, reviewed, and revised over time, depending on the needs and goals of the consumer.

### 1.5.1 Are the consumer's care goals, action steps to meet those goals, and proposed interventions to overcome identified challenges documented in the IPC?

IDT members need to be trained in working with and guiding consumers in identifying their personal goals – medical, social, or other (see 1.1.1 above).

### 1.5.2 Does the IPC contain specific documentation of what formal (paid) and informal (unpaid) care and supports are needed as well as care and support services are being provided?

Organizations with geriatric capacity ensure that accountability and timeframes are built into the IPC. Automated reminders are helpful in ensuring that IDT members regularly review and update the IPC. A checklist of such formal and informal services and supports may include: primary care, acute care, wellness care, behavioral health care, rehabilitation services, health education, transportation, personal care, housing with support pre-employment training, employment supports, social services, caregiver support, transitional care, assistive technology, money management, care management, and other care requested/specified by specialist physicians.

### 1.5.3 Do IDT members ensure that consumers understand and feel empowered to accept, negotiate, or modify changes made to their IPC?

Geriatric-competent organizations provide their staff with specific training and coaching to be sensitive to any consumer disagreement or resistance of care needs and goals specified in their IPC. Staff are trained to work with consumers to ensure concerns are addressed and consumers are aware of benefits and risks related to the IPC. For individuals with certain conditions (e.g., Alzheimer's disease), organizations may need to interact more closely with the consumer's family members or caregiver to address concerns or modify the IPC.

### 1.5.4 Do consumers and all members of the IDT have full access (electronically or on paper) to the initial IPC and any subsequent changes or updates?

Ideally the consumer's IPC is electronic and available to the consumer and all authorized providers (including those providing after-hours care). A paper version can serve as a substitute, especially if desired by the older consumer. The IPC should reside in a "central" location so the consumer and all authorized providers can reference it as needed. For paper versions of the IPC, copies should be made available to all members of the IDT.

## **1.6 Individualized and Person-Centered Plan of Care Oversight and Coordination**

Ongoing oversight and review of the IPC is needed to ensure the plans are effective and being followed, that preventive strategies are in place, and that revisions are made based on the consumer's changing needs.

### **1.6.1 Are IDT members alerted when a consumer has a change in health status or care needs that affects the IPC?**

Many geriatric-competent organizations use methods such as electronic triggers and signals to alert IDT members to needed or actual changes to the care plan. The types of changes that would be important for team members to know about are IPC review dates, changes in medications, routine reviews, hospitalizations, etc.

### **1.6.2 Is the IDT provided with clear criteria as to when a change in a consumer's health, condition, or caregiver status requires a revision to his or her IPC?**

Criteria to trigger a review and possible revision to an IPC would include 1) consumer is receiving acute care such as a hospitalization, 2) consumer is in transition from one setting of care to another setting of care, 3) changes in consumer health or caregiver status, and 4) routine, prescheduled reviews. Unique elements such as death of the consumer's spouse might also be considered a trigger requiring review of the consumer's IPC.

### **1.6.3 Is the IDT provided with timely reminders to guide their work with each consumer as specified in the IPC?**

Many organizations with geriatric capacity use methods such as electronic triggers to remind IDT members of outstanding items in a consumer's IPC that require attention.

## 1.7 Transitions

Transitions include changes between care settings, providers of care, and medications as well as financial, housing, legal, employment, and other changes that affect the older consumer's ability to live independently. It is during these transition times that misunderstandings, missed care and a variety of other errors occur may occur. Older adults have limited physiologic reserves and are at-risk of bad outcomes during poorly handled transitions. Those mishaps are more likely to be the cause of readmissions to acute care, set-backs in independence, and/or emotional or physical hardship. All transitions require vigilance by the IDT to identify and oversee the change to ensure the safety and well-being of the consumer.

### 1.7.1 Are there protocols to assist IDT members in managing key types of transitions?

Many organizations with geriatric expertise provide protocols that may be used for different types of transitions. Other organizations may employ a universal checklist of actions to be undertaken during different types of transitions. For example, following a discharge, a consumer should receive regularly scheduled follow-up from the provider to ensure that the discharge was successful. Transitions for consumers with cognitive impairments (e.g., Alzheimer's disease) may be particularly challenging, as this consumer population is often reliant on visual cues and other familiarities that may not be available in new settings.

### 1.7.2 Is a transition plan developed and implemented for all significant consumer changes?

Significant changes include all transitions that involve more than one area of the consumer's life. The IDT will want to ensure all care transitions are well documented and that all aspects of any transition, such as assistance with moving expenses or home modifications, are addressed.

### 1.7.3 Do all consumer transitions have an IDT member identified as responsible for ensuring successful completion and timely follow up?

For example, if the transition involves changes in medications, one IDT member may be responsible for providing medication reconciliation or coaching on signs and symptoms. This same individual would be responsible for bringing to the attention of the IDT that the consumer has a medication change. The IDT member would be alert for incomplete action items such as pending diagnostic tests or unscheduled medical appointments. Significant changes in health, function or caregiver support require not only revision of the IPC, but also education of the consumer and caregivers to assure they are confident about the new plan and have acquired new self-care skills, if necessary. The IDT confirms understanding through the use of "teach-back" and similar techniques. The transition plan includes at least one IDT member to be available to answer questions that emerge post-transition.

### **1.7.4 Are peer support and counseling services available to consumers considering or undertaking a transition process?**

The IDT would want to make a list of resources available to the consumer for peer support and other counseling services, such as local Centers for Independent Living, Area Agencies on Aging, and Aging and Disability Resource Centers. The IDT may also add condition-specific resources to this list, such as Alzheimer's Association local chapters.

### **1.7.5 Does a significant change in the consumer's functional capacity trigger consideration of a potential transition plan?**

Any significant change in a consumer's functional capacity, as demonstrated by a need to increase the type, amount or location of care, would necessitate the development of a transition plan. The transition plan may be a separate document, but would be included as a component of the IPC.

### **1.7.6 Does the IDT collaborate and provide resources to the caregiver or family member to assist with the transition?**

Family members or caregivers may be essential partners to ensure a smooth and coordinated care transition. For certain consumer populations (e.g., individuals with Alzheimer's disease) or types of transitions (e.g., hospitalizations), IDT members may work with family members or caregivers to develop pre-planning checklists to prepare for the transition.<sup>3</sup>

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<sup>3</sup> Collaboration for Homecare Advances in Management and Practice (CHAMP): Advancing Home Care Excellence. Geriatric Care Transitions Toolkit: <http://www.champ-program.org/page/100/geriatric-care-transitions-toolkit>

## 1.8 Tailoring Services and Supports

Specific services and supports listed in the IPC should be derived from the assessments. They will also need to be modified as appropriate. The IPC specifies the individualized services and supports that are reflective of the consumer's preferences and needs to achieve his or her goals.

### 1.8.1 Are traditional services/supports substituted with alternative services that might not be considered "covered services" when appropriate?

Organizations with geriatric expertise consider all alternatives and assess the long-term benefit of providing the service/support, consumer preference, and cost-effectiveness. Examples include alternative transportation services, support groups, moving services, assistive technology loan programs, and complementary or alternative therapies (e.g., acupuncture, reiki, massage, curanderismo healing, etc.). Additionally, consumers are commonly the best source of creative, cost-effective alternatives. For example, consumers may identify a faith-based support group that can be rallied for a short period of time.

### 1.8.2 Does the IDT have the authority to modify the means of care delivery based on the unique context of the individual or a specific change in condition (either temporary or long-term)?

Organizations known for geriatric capacity empower the IDT to alter the scope, intensity, and frequency of care delivery, supports, and services when warranted. If managed care is involved, and authorization is required for resources, the criteria used for service authorization is made transparent to consumers and relevant providers.

## 1.9 Advance Care Planning

Completing and honoring advance care planning is an interactive process between the consumer and his or her IDT. The consumer's wishes help determine the course of his or her care and the identification of a proxy helps to ensure his or her wishes are honored in the event of the consumer's loss of capacity to make decisions. Geriatric-competent care requires IDT members being able to discuss end-of-life care issues with respect, sensitivity, and awareness. See Section 7.2 for a discussion of Advance Directives components (i.e., living wills, durable power of attorney for health care and mental health care). Other end-of-life care issues may include Do Not Resuscitate (DNR) orders, plans for palliative or hospice care, ventilator use, and artificial nutrition or hydration.

For consumers with cognitive impairment (e.g., Alzheimer's disease), loss of memory may impact their ability to participate meaningfully in decision making and makes early planning even more important. Although difficult questions often arise, advance planning can help people with Alzheimer's disease and their families clarify their wishes and make well-informed decisions about health care arrangements. When possible, the IDT may want to initiate advance care planning conversations soon after a diagnosis of early-stage Alzheimer's disease, while the consumer can still contribute and express clear and well-informed decisions.

### 1.9.1 Are consumers routinely asked to consider advance care planning?

Most organizations with geriatric capacity include a question or section regarding advance care planning, advance directives and other end-of-life care issues in the initial and recurring assessments.

### 1.9.2 Are staff trained in coaching consumers on advance care planning and end-of-life care decisions?

Many consumers expect health care providers to take the lead in discussions about health care decisions and advanced directives. Organizations with geriatric expertise will establish training for staff on how to effectively coach consumers on advance care planning and end-of-life care decisions, with sensitivity to diverse perspectives related to culture, disability, cognition and individual values and preferences.

### 1.9.3 Are consumers offered counseling or assistance in advance care planning?

Organizations should ensure consumers have competent guidance and assistance in completing advance care planning. Due to familiarity, trust, and openness, the consumer's primary contact on the IDT may provide this assistance to the consumer.

### 1.9.4 Are all advance care plans reviewed by the IDT and revisited at least annually with each consumer?

Triggers embedded in the IPC may serve as helpful reminders for the IDT to engage consumers in advance care planning discussions on an annual basis.

**1.9.5 Are all completed advance care plans documented in the consumer's health record for access by all providers, including those providing after-hours care?**

Signed copies of advance directives and other end-of-life documents should be sent to the consumer's primary care physician (if not a member of the IDT) and the consumer's preferred hospital, and should be entered into the EHR.

## 1.10 Allocation of Care Management and Services

Consumers need varying levels of care management support and assistance. The allocation methodology should be derived from the assessments and noted in the IPC.

### 1.10.1 Is there a process for determining the nature and amount of care management required by each consumer?

The following elements should be considered when assessing care management needs:

- Desire and ability to self-manage
- Functional dependencies
- Behavioral health issues
- Availability of home- and family-based supports
- Social and financial supports
- Frequency of inpatient and emergency department utilization
- Cognitive impairment and abilities
- Number of chronic conditions
- Risk for secondary complications of disability or chronic conditions, if applicable
- Complexity of IPC and stability of the formal/informal support team

### 1.10.2 Are consumer expectations and preferences a routine part of the assessment process for determining care management support provided by the IDT or other designated person?

It is important to specifically discuss the frequency and nature of care management to be provided as part of the assessment process so that the consumer's expectations are identified, discussed, and met.

### 1.10.3 Does the IDT review and discuss the consumer's expectations of care management during all reassessments to ensure he or she receives the level, nature, and timeliness of care management he or she desires and requires?

Encourage each consumer to communicate about the needed care, supports, and services he or she feels are lacking and encourage the consumer to give feedback to the IDT on whether or not expectations are met.

### 1.10.4 Are consumers specifically coached as to when and how they may seek and obtain care management support?

Geriatric-competent organizations encourage consumers to call their primary care practitioner, care manager, or IDT lead upon first indication of illness so that plans can be implemented to ensure the appropriate level of care.

## 1.11 Interacting with Care Partners

Care partners (usually unpaid) are spouses, friends, or relatives who provide assistance to the consumer. Another term for these valuable resources is “natural supports” or “informal” support. The key criterion is that these individuals provide valuable help without being monetarily compensated. An example is the daughter who helps the consumer dress and bathe, or neighbors who helps the consumer with grocery shopping because they are willing and able to do this for the consumer. Refer to **Domain 5 - Caregiving** for more information on informal support.

### 1.11.1 Does the IDT routinely inquire whether consumers have an ongoing care partner who accompanies the consumer to medical appointments, and does the IDT recommend this process when necessary?

A care partner can provide assistance to the consumer who has complex care needs or cognitive limitations, such as accompanying the consumer to medical appointments. The care partner can coach the consumer to ask questions during the appointment, assist with adherence to the care plan, and provide support while the consumer is accessing care. In the case of consumers previously diagnosed with Alzheimer’s disease, the presence of a legal guardian or care partner may be necessary to ensure that the consumer’s choices are respected and incorporated into the care plan. IDTs can have a process in place to recommend that a legal guardian or care partner is present during medical appointments, when necessary.

### 1.11.2 Is there a means of communication established between the IDT and the identified care partner?

The presence of a care partner ought to be noted in the consumer’s IPC with documentation regarding the nature and means for communication between the IDT and care partner. It is important to understand the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule when sharing information with the consumer’s care partners.<sup>4</sup>

### 1.11.3 Are care partners offered training to prepare them for their support role?

This training is usually informal, though it may include specific evidence-based education regarding preventive strategies and identification of warning signs, such as “Savvy Caregiver.”<sup>5</sup> Additionally, training may include condition-specific content, such as training to care for consumers with Alzheimer’s disease.<sup>6</sup> It is also important to evaluate the care partner’s ability and interest in serving in this role.

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<sup>4</sup> The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is the first comprehensive Federal protection for the privacy of personal health information. [http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/HIPAAGenInfo/06\\_AreYouCoveredEntity.asp](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/HIPAAGenInfo/06_AreYouCoveredEntity.asp)

<sup>5</sup> US DHHS Administration for Community Living, Administration on Aging: An Evidence-Based Intervention for Alzheimer’s and Dementia Care. [http://www.aoa.acl.gov/AoA\\_Programs/HPW/Alz\\_Grants/caregiver.aspx](http://www.aoa.acl.gov/AoA_Programs/HPW/Alz_Grants/caregiver.aspx)

<sup>6</sup> Online resources such as the National Institute on Aging and the Alzheimer’s Association, offer many tips and guidelines: <http://www.alz.org/care/alzheimers-dementia-care-training-certification.asp>

## 1.12 Health Record

A comprehensive health record is composed of many elements, including assessment(s), the IPC, medication lists, referrals and authorizations, care management notes, and other information as appropriate. The IDT overseeing the overall plan of care is responsible for having and maintaining a comprehensive health record for each consumer. Having an electronic health record (EHR) for each consumer aids communication and coordination but the IDT will want to be cognizant that not all involved in a particular consumer's care will have the capability of accessing or be able to generate electronic records.

### **1.12.1 Is all information (e.g., medical, social, medications, financial) for each consumer documented, maintained, and updated within the health record for that?**

The consumer's health record is ideally available via electronic means. If this is not possible, the health record should be available to the consumer and all providers via paper, fax, or email.

### **1.12.2 If an EHR is maintained, is it interoperable with EHRs of key providers involved in the consumer's care?**

At a minimum, a paper or electronic document is shared with all providers involved in the consumer's care. The ideal is to have an EHR that is able to incorporate the medical records, care management activities, and service plans from all providers and settings engaged in the consumer's care.

### **1.12.3 Does an IDT member or support person specifically manage, update, and disseminate each consumer's information to appropriate providers as discussed with and approved by the consumer?**

This person is typically a clinical office-based team assistant or support person available during working hours to facilitate communications. In non-clinical settings or with non-primary care entities, agreements may be in place with accountable care or managed care organizations to provide full or partial access to EHR information.

### **1.12.4 Is there a means to quickly access, communicate, and disseminate key consumer information, especially for anyone providing after-hours coverage?**

Geriatric-competent organizations commonly provide key information in a readily accessible location (e.g. a virtual "front page" or summary screens) of the consumer's EHR. If there is no EHR, the IDT will have protocols and a means to provide key information. Consumers with Alzheimer's disease may require real-time tracking programs, such as Silver Alert or MedicAlert, to help prevent and mitigate the risk of wandering.

### **1.12.5 Is utilization data in the health record routinely reviewed by the IDT to identify areas for clinical intervention and quality improvement?**

It is very helpful to have real-time administrative data for emergency department visits and inpatient hospital admissions (including diagnostic information) to identify potentially preventable admissions or conditions that are amenable to health education and enhanced consumer support. Additionally, real-time pharmaceutical data is useful to identify a change in condition, track adherence, and enhance comprehensive medication management, including but not limited to medication reconciliation.

### **1.12.6 Is pertinent clinical and utilization data routinely provided to external providers to identify opportunities for improvement?**

Data on consumer costs, emergency department visits, specialty referrals, behavioral health services, pharmaceutical services, inpatient hospital admissions, LTSS utilization, care management contacts and risk indicators (e.g., falls, high alert medicines) can be used to create management reports that serve as a source of feedback and as opportunities to coach providers. Reports reflecting the experience of a provider's full panel of consumers provide an opportunity to identify promising practices and areas for improvement. Predictive modeling may identify key variables associated with health care and LTSS utilization that enable providers to tailor services and intervene to optimize clinical and financial outcomes.

### **1.12.7 Does the consumer have the ability to access all components of his or her health record?**

At a minimum, the consumer should be able to review all components of his or her health record during visits with his or her primary care practitioner.

# APPENDIX A: REFERENCES AND RESOURCES

Included in this appendix are references that were utilized and consulted during the development of this Tool or augment the information contained in the assessment tool. References are links to government websites, resources provided by professional organizations, or publications in academic journals. The references are divided by domain for ease of use.

## Introduction

- **Slow medicine:**  
[http://www.nytimes.com/2008/02/26/health/views/26books.html?\\_r=1&](http://www.nytimes.com/2008/02/26/health/views/26books.html?_r=1&)
- **Geriatric Competencies:**  
<http://www.pogoe.org/gwiz>
- **Geriatrics Competent Care Webinar Series:**  
[http://www.resourcesforintegratedcare.com/Geriatrics\\_Compentent\\_Care\\_Webinar\\_series](http://www.resourcesforintegratedcare.com/Geriatrics_Compentent_Care_Webinar_series)

## 1. Relational-based Care Management

- **Patient-Centered Primary Care Collaborative:**  
<http://www.pcpcc.org/>
- **Patient-Centered Care:**  
<http://pcmh.ahrq.gov/page/patient-centered-care>  
<http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/>
- **Relational-Based Care:**  
<http://chcm.com/relationship-based-care/>
- **Basic cognitive assessment tools:**  
<http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp#patientassesstools>
- **Collaboration for Homecare Advances in Management and Practice (CHAMP): Advancing Home Care Excellence. Geriatric Care Transitions Toolkit:**  
<http://www.champ-program.org/page/100/geriatric-care-transitions-toolkit>
- **The Alzheimer's Association offers many tips and guidelines for caregiver resources:**  
<http://www.alz.org/care/alzheimers-dementia-care-training-certification.asp>

# ACKNOWLEDGEMENTS

We would like to acknowledge the many providers, care organizations, and caregivers who provided input and guidance for this document. A special thanks to Sheila Molony of Connecticut Community Care for her invaluable comments.

This document represents one domain of an eight-part self-assessment tool. To access additional domains, or to see the tool as a whole, please visit:

<https://www.resourcesforintegratedcare.com/>. We also welcome any feedback to [RIC@Lewin.com](mailto:RIC@Lewin.com).