GERIATRIC SERVICES CAPACITY ASSESSMENT

DOMAIN 2 – HIGHLY RESPONSIVE PRIMARY CARE

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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.

2 HIGHLY RESPONSIVE PRIMARY CARE

A highly responsive primary care network is critical for timely, ongoing, and accessible care. The provision of primary care is a vital component of competent geriatric care. It requires timely access to care regardless of the setting (in a clinical office, community, or consumer's home) as well as the ability to assess and address newly emerging symptoms or concerns, and the allocation of care and services. Many of the following elements (e.g., primary care network capacity) are focused within the health care medical system but non-primary care entities would do well to understand their importance in the overall well-being of the elderly population being served. Some elements, though targeted to the medical system, can be adapted by community organizations to fit their services, structure, and processes.

2.1 Primary Care Network Capacity

The capacity of an organization's primary care network to provide geriatric care should be considered since a significant number of external providers may not be experienced in providing care for seniors, especially those seniors who have Medicare-Medicaid coverage. In addition, primary care providers are often responsible for conducting screenings during annual visits (e.g., routine assessments for cognitive decline) and are often the first points of contact to diagnose changes in health and refer consumers to specialists and other community resources.

2.1.1 Does your organization assess the geriatric capacity of provider networks?

When engaging with external primary care practices, many organizations that provide care extensively to older adults will designate a lead geriatric practitioner or point person to provide ongoing oversight and coaching to the external practice and its practitioners.

2.1.2 Are strategies employed to help primary care practitioners enhance their geriatric awareness and competencies?

Organizations that serve the geriatric population often offer a provider training program for staff members and may contract with organizations that have expertise in geriatrics to provide in-service training and networking opportunities. Organizations may also provide Continuing Education Units (CEUs). Training may include:

- Geriatric philosophy and approach to care
- Altered (and non-specific) presentations of disease in older adults
- Hidden illnesses (e.g., depression, hearing loss, incontinence, dementia, dental problems, poor nutrition, alcoholism, sexual dysfunction, osteoporosis)
- Geriatric syndromes, e.g. falls, sleep problems, urinary incontinence
- Cognitive impairments (e.g., Alzheimer's disease)
- Comprehensive medication management (including content regarding polypharmacy, potentially inappropriate and high alert medications, adverse drug reactions, protocols for medication discontinuation, proper dosing)
- Functional assessment, frailty, patterns of disability and habilitation
- Abuse/mistreatment
- Driving assessment, safety and cessation
- Palliative care

2.1.3 Do all primary care practices have a network of accessible geriatric-competent providers for basic diagnostic tests, including x-ray and laboratory testing?

Maintain a list of preferred providers with capacity and competency in geriatrics and keep the list in a centrally accessible record.

2.1.4 Are there strategies that primary care providers can use to help them become more aware and competent to care for the geriatric population?

Organizations with geriatric expertise may provide practices with a checklist on the structural elements needed to provide excellent geriatric care (e.g., ramps, wheelchair scales, accessible entry points) as well as guidance for staff related to topics such as enhancing in-person and telephonic communication (for consumers with speech, visual, and hearing impairments). Guidance may also be provided regarding strategies to enhance and maintain access to care, continuity and consistency in communication. These strategies may include proactive planning with consumers, care partners, care managers, transportation providers and others. Organizations may provide home-based primary care visits for consumers with severe mobility challenges (See Section 2.2.2).

2.1.5 Are there strategies in place to ensure integration of primary care and behavioral health, as well as close collaboration between primary care, behavioral health, and LTSS providers?

Geriatric care requires integration of behavioral health with primary care and LTSS.[1] Integration can take many forms, including co-location; integrated or full access to the EHR by behavioral health providers and LTSS care managers; or regular participation in IDT meetings.

2.1.6 Do all primary care practitioners have access to a network of medical sub-specialists who are experienced in providing care for geriatric consumers?

Maintain a list of preferred geriatric-capable sub-specialists and keep it in a centrally accessible record. Sub-specialists include, but may not be limited to:

- Neurology
- Physiatry
- Cardiology
- Pulmonology
- Endocrinology
- Urology
- Gastroenterology
- Pain Management
- Behavioral Health
- Oncology
- Hearing/audiology

[1] Finding or training geriatric behavioral health practitioners is an ongoing challenge in most localities; an increasing and diversifying geriatric population has resulted in a critically low number of behavior health providers that are able to serve these consumers. One strategy is to contract with health plans/providers that co-locate mental health services in primary care clinics or place primary care providers in mental health clinics.

- Podiatry
- Geropsychiatry

2.1.7 Is there a mechanism to track the performance of non-primary care entities?

Many organizations serving older adults will create reports for their care partner who may only serve a small number of consumers. These reports focus on outcomes of care as well as care planning functions such as timeliness, appropriateness, continuity of care, and medication management. In turn, external practitioners would share outcomes with the primary care practitioners in efforts to improve integrated care and services to the elderly population.

2.1.8 Do primary care providers use care guidelines to observe for secondary complications of chronic conditions or common problems associated with aging?

Prevention of common problems and secondary complications is critical for geriatric care. Geriatric providers will use care guidelines for the following, at a minimal:

- Pressure ulcers
- Pneumonia
- Upper respiratory infections
- Urinary tract infections
- Stool impaction
- Delirium
- Functional decline related to disuse and deconditioning
- Sleep disruption
- Polypharmacy and adverse drug effect

2.2 Availability of Care

The timeliness of primary care is often the key factor in reducing emergency department and inpatient utilization and costs.

2.2.1 Are primary care practitioners available for diagnosis and treatment at all times?

Some organizations opt to hire or contract with primary care physicians and/or nurse practitioners who provide coverage after-hours and/or on stand-by, working in partnership with a broader primary care practitioner network.

2.2.2 Are primary care practitioners available to provide care in the community (clinic or place of residence)?

Providing direct care in the community or individual's place of residence is often necessary, as transportation can be difficult to arrange and is a key barrier to accessing timely care. Some organizations opt to hire or contract with primary care physicians and/or nurse practitioners to make home visits and take calls as needed from geriatric consumers.

2.2.3 Are primary care practitioners' schedules adequately flexible to provide same-day episodic care assessment and clinical management?

Organizations or practices serving a large number of geriatric individuals recognize that this population may need same-day intervention to avoid further complications. Some practices also might augment clinic-based primary care physician services by having nurse practitioners available for home visits or in-clinic consultations.

2.2.4 Are mental and behavioral health crisis intervention services available at all times?

Some geriatric-capable organizations contract with crisis intervention providers and peer-support workers who can respond to geriatric consumers with behavioral health needs. This would extend to the provision of home-based services and emergency accessible transportation.

2.2.5 If applicable, do non-primary care entities routinely communicate with the IDT or primary care manager to ensure adherence to treatment plans and follow up on referrals?

Ongoing communication among members of the IDT is essential for optimal geriatric care and requires special attention when a consumer routinely engages community providers and medical specialist in addition to his or her IDT.

2.3 Medication Management

2.3.1 Are all medications reviewed at assessment, reassessment, transitions, and when there is a significant change in condition?

Organizations that serve geriatric individuals in an optimal capacity include a review of medications during all visits with each consumer. There are gaps generally in the understanding of medication use in the older person because safety and effectiveness are not well studied in the aged population. It is known that multiple concomitant meds adversely affect safety and effectiveness in the older consumer, but it is not known that new drug treatments may lead to adverse drug reactions and drug-drug/drug-disease interactions. It is also known that the older individual is more sensitive to many medications. Practitioners routinely investigate whether medication is a possible contributor to new symptoms and changes in health or function. Geriatric-competent organizations provide training and guidelines in comprehensive medication management, medication review, medication reconciliation and medication discontinuation or tapering. Providers identify and mitigate medication usage concerns related to poor vision, limited strength and manual dexterity, impaired memory, limited funds, and the complexity of medications (e.g., inhalers). Geriatric-competent practitioners recognize that some medications pose greater risks than benefits for older adults with certain conditions irrespective of diagnosis/condition. See **Domain 8 – Geriatric Assessment** in this Tool for more information about the Beers Criteria, which assists health care providers in improving medication safety in older adults.

2.3.2 Is a consulting clinical pharmacist available to the IDT to assess and address polypharmacy and inappropriate prescribing?

Geriatric capability involves developing criteria for when to engage clinical pharmacists. This may be done on an annual basis or when the consumer is on a defined number of medications (it is common for consumers, to be prescribed multiple medications from multiple physicians). The primary care practitioner on the IDT assumes responsibility for having the medications reviewed and managed. Over-the-counter medicines, vitamins, supplements and natural remedies are included in medication reviews, and, with explicit permission from the consumer, care partners are included in medication assessment and education.

2.3.3 Is the consumer's primary care practitioner informed when another practitioner orders a medication change?

Geriatric-capable organizations typically build these notifications into care management software, along with regularly updated medication fill reports. With the continuing development and availability of electronic health records, this integration and sharing of vital information can be facilitated for the benefit of the older person. Notifications may be designed to identify high alert medicines, therapeutic duplication and dosing concerns.

2.3.4 Are consumers and their caregivers trained in medication administration, if needed?

Providers will want to assess the consumer's ability to manage his or her medication regime. Geriatric practitioners will want to assure that the consumer has the tools needed for self-management (such as medication cases, easy-open medication caps, large print labels, bubble-wrapped dosing, or medication dispenser devices). Consumers with certain conditions (e.g., Alzheimer's disease) may be prescribed multiple medications and may have a harder time tracking or remembering proper medication management. In these cases, it is even more important to train caregivers and equip them with necessary resources. Tips for consumers and caregivers can include developing strict routines for administering medications, using pill box organizers, and using automatic pill dispensers.[2]

[2] Collaboration for Homecare Advances in Management and Practice (CHAMP): Advancing Home Care Excellence. Geriatric Medication Management Toolkit: http://www.champ-program.org/page/101/geriatric-medication-management-toolkit

2.4 Communication, Equipment, and Physical Access

2.4.1 Do consumers have access to the care and equipment they need to maximize health and independence, both in and outside the home?

If a consumer utilizes equipment in the home, such as lifts, arrangements will need to be made to have comparable equipment available at all other sites where the consumer receives care. Understanding the individual needs of each geriatric consumer facilitates care and ensures the safety of that person when he or she is in a setting other than his or her own home.

2.4.2 Do all care settings offer communication access that includes translation?

Communication facilitation may include:

- Amplification devices
- In-office communication devices
- Communications facilitator/care partner
- Telemedicine for geriatric consumers living remotely[3]
- Medi-Alert
- Foreign language translation
- American Sign Language (ASL) and ASL interpreters
- Teletypewriter (TTY)[4] and text support for mobile phone or Internet-based communication

2.4.3 Do organizations modify communications for consumers with cognitive impairments?

Communication can be difficult for people with cognitive impairments. Consumers with Alzheimer's disease and other dementias may have problems with finding the right word or losing train of thought when speaking; understanding what words mean; paying attention during long conversations; and being very sensitive to touch and to the tone and loudness of voices. Organizations should work with their providers to understand how to make communication easier for these consumers, and make resources and trainings, such as through the National Institute on Aging, available.[5]

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[3] Telemedicine is the exchange of medical information from one electronic site to another, in the interest of improving a consumer's clinical health status.

[4] TTY is a data terminal that converts incoming phone calls and voice responses into text. This device assists the hearing impaired in using the telephone.

[5] National Institute on Aging. Communication and Behavior Problems: Resources for Alzheimer's Caregivers. https://www.nia.nih.gov/alzheimers/communication-and-behavior-problems-resources-alzheimers-caregivers

2.4.4 Are offices, including home- and community-based service settings arranged for easy access, minimal hazards, and as a pleasant, reassuring, age-friendly environment?

Geriatric capacity includes awareness on the part of providers of accessibility, especially of clinic/day health/care setting entrances, parking facilities, hallways, waiting rooms, restrooms, elevators, and examination rooms (e.g., physically accessible to both manual and motorized wheelchair users). Pathways are straightforward and free of clutter, bright lights enhancing visibility are in place, glare is reduced, background noise is minimized, and age-appropriate music and reading material are available.

2.4.5 Do primary care practices and other care settings have adequate equipment (such as scales, exam tables, and lift equipment) to provide comprehensive care for members with physical and cognitive impairments?

Geriatric-competent primary care practices would include wheelchair accessible examination tables, scales and lifts. Bathrooms, waiting areas and corridors are fully accessible. Equipment is available to facilitate communication and examination (e.g., amplification devices, small, medium, large and extra-large blood pressure cuffs, etc.).

2.5 Preventive Care and Health Education

Optimal geriatric care requires a focus on maintaining health, optimizing function, and preventing avoidable complications. Providers will want to carefully consider whether all recommended immunizations and screenings are necessary for the older consumer. Frail older adults have limited physiological reserve that, if taxed with too many medical tests, treatments, and medications, could be depleted without easy recovery. Providers will also want to consider preventive activities, such as fall prevention, that are specifically applicable for the older consumer.

2.5.1 Do primary care practitioners have guidance on how to tailor care protocols and registries for the management of chronic conditions for geriatric consumers?

Traditional protocols and practices for management of chronic conditions must be tailored to each consumer to factor in his or her other needs, medications, functional status, and available supports. An individual with insulin dependent diabetes whose eyesight is failing may need additional tools to conduct blood sugar testing or a different range of blood sugar results for units of insulin to be administered.

Registries (sometimes called provider profiles) allow providers across an organization or health plan to compare and contrast their consumer populations based on certain criteria such as diseases and chronic conditions. This can help to ensure standardized quality goals within the organization and to target consumers for additional health education, more frequent visits, or additional care management. A geriatric provider may want to consider tailoring a registry to better suit an older population and the conditions that they experience more frequently.

2.5.2 Are consumers and caregivers/personal care assistants provided with health promotion information specific to the consumer?

An Individual Plan of Care includes a health and wellness plan, including:

- Living a healthy lifestyle (activity, nutrition, psychosocial health promotion, health practices)
- Accessing primary care
- Routine health prevention services
- Chronic disease self-management (including any condition that limits function or quality of life)
- Prevention of secondary disability or complications
- Safety and emergency plans
- Medication management to assure supply and actions to take in the event of a missed dose or adverse reaction
- Caregiver back-up plan (as applicable) for when a caregiver is not able to assist the consumer. See 5.1.6 (**Domain 5 – Caregiving**) for more information on caregiver back-up planning.

2.5.3 Do primary care practitioners follow clinical protocols for the identification and treatment of key secondary conditions related to functional capacity in the older adult?

Geriatric care organizations typically have clinical protocols for the identification and treatment of skin breakdown, urinary tract infections, upper respiratory infections, bowel impaction, depression, and other secondary complications (see 2.1.8 above).

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&
- **Geriatric Competencies:** http://www.pogoe.org/gwiz
- **Geriatrics Competent Care Webinar Series:** https://www.resourcesforintegratedcare.com/Geriatrics_Competent_Care_Webinar_series

2. Highly Responsive Primary Care

- **Telemedicine:** http://www.americantelemed.org/about-telemedicine/what-is-telemedicine
- **Medication Management:** http://www.americangeriatrics.org/files/documents/annual_meeting/2013/handouts/sunday/U1230-5514_Hal_H._Atkinson.pdf
- **Geriatric Assessment:** http://geriatrics.stanford.edu/culturemed/overview/assessment.html http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations
- **U.S. Preventative Services Task Force:** http://www.uspreventiveservicestaskforce.org/
- **Geriatrics:** http://www.acponline.org/patients_families/about_internal_medicine/subspecialties/geriatrics/
- **National Institute on Aging. Communication and Behavior Problems: Resources for Alzheimer's Caregivers**. https://www.nia.nih.gov/alzheimers/communication-and-behavior-problems-resources-alzheimers-caregivers
- **Collaboration for Homecare Advances in Management and Practice (CHAMP): Advancing Home Care Excellence. Geriatric Medication Management Toolkit:** http://www.champ-program.org/page/101/geriatric-medication-management-toolkit

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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.