## Q&A FOR GERIATRICS-COMPETENT CARE WEBINAR SERIES
## Webinar 1: Overview of Geriatrics-Competent Care

**Q1. Is the work of researchers like Emily Agree and Lois Verbrugge part of geriatric assessment?**
A: It can be. Most social service assessment forms have been fairly static for decades because the government funding sources determine the content. We have an opportunity now to adopt new evidence-based approaches such as those suggested by Emily Agree. One limiting factor is time, both from the cost perspective and because the barrage of questions can be exhausting for frail older adults. So most questions must serve multiple purposes, however in in the social services sector, the main purpose is to determine needs and make arrangements to fill those needs.

**Q2. Please clarify Dr. Warshaw's comment about 100 years being standard.**
A: The **life span** is the maximum number of years an individual from a given species can live. For humans, the current accepted *maximum life span* is 122 years achieved by Jeane Clament of France. Life span is different from **life expectancy** (http://longevity.about.com/od/longevity101/p/life_expect.htm), which is the average number of years a person can expect to live. At birth, in the United States, men have an average life expectancy of 76 years and for women it is 81 years. Men who survive to age 65 years can, on average, expect to live to age 82 years, and those surviving to age 85 years can expect to live to age 90 years. Women who survive to age 65 years can, on average, expect to live to age 84 years, and those surviving to age 85 years can expect to live to age 91 years. Closing the gap between life expectancy and life span can be done through healthier living, less exposure to toxins and the prevention of chronic illnesses.

**Q3. Should pain/opiate medications and alcohol usage be included in assessing fall risk?**
A: All medications and alcohol use should be reviewed as part of a falls assessment.

**Q4. Where can I find evidence-based programs for elder patients and family caregivers?**
A: There is a list of evidence-based programs on slide 52 of the Geriatrics-Competent Care webinar presentation (https://www.resourcesforintegratedcare.com/sites/default/files/GCC_Webinar1_IntroductionGCC.pdf). Additional information on evidence-based self-management programs can be found on the Administration on Aging (http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx) and Healthy Living Center for Excellence (http://www.healthyliving4me.org/) websites. The National Council on Aging's Center for Healthy Aging (http://www.ncoa.org/improve-health/center-for-healthy-aging/) also offers a wide range of information. Finally, a list of evidence-based care transition programs is on the Administration for Community Living (http://www.acl.gov/Programs/CDAP/OIP/EvidenceBasedCare/index.aspx) website.

**Q5. Do social workers do psychosocial and environmental assessments?**
A: Social workers do psychosocial and environmental geriatric assessments. However, a social worker may identify the need to refer the individual for a more in-depth assessment and

treatment. For example, an individual experiencing significant depression or adjustment disorders may benefit from medication evaluation by a physician or ongoing counseling from a mental health professional. Similarly, an individual who is experiencing difficulty in navigating within the home may benefit from a referral to a physical or occupational therapist that can evaluate for possible therapy sessions and/or make recommendations for adaptive and assistive equipment/devices. The social worker, with the consent of the individual, can make those referrals, then discuss the results of the follow-up assessment with the individual and the consulting professionals to assist as indicated with whatever plan of action has been developed.

**Q6. What is the best way to advocate for those who have different cultures (e.g., elders of color and caregivers of color) and are not familiar with formal services due to their cultural background in an effort to introduce them to evidence-based programs?**
A: There are several evidence-based self-management programs offered in different languages. For instance, the Stanford Patient Education Research Center has developed three Spanish-language versions of their highly-regarded self-management programs:

- Tomando Control de su Salud (http://patienteducation.stanford.edu/programs_spanish/tomando.html) (Chronic Disease)
- Tomando Control de su Diabetes (http://patienteducation.stanford.edu/programs_spanish/diabetesspan.html) (Diabetes)
- Programa de Manejo Personal de la Artritis (http://patienteducation.stanford.edu/programs_spanish/asmpesp.html) (Arthritis)

These programs are available through many state-based organizations such as Area Agencies on Aging and other community-based organizations serving older adults. A list of states offering these programs, and the partnering organizations within those states, can be found on the Administration on Aging (http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx) website.

**Q7. What's a dual?**
A: A "dual" or a "dual eligible" refers to someone with both Medicare and Medicaid. This typically includes low-income seniors and younger people with disabilities. There are over 10 million dual eligibles in the United States (Source: http://hub.healthdata.gov/dataset?tags=dual-eligibles).

**Q8. How does one access the guidelines for the self-management programs?**
A: As noted earlier, the Administration on Aging has a list of such programs on their website: http://www.aoa.gov/

**Q9. What are the preferred methods of educating the elderly population on the community-based services available to them?**

A: Referring older adults to their local senior center, area agency or office on aging, and the Eldercare Locator (http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx) are good ways to direct older adults to community-based services. Other good resources are specific disease-related non-profit organizations such as the Alzheimer's Association, the American Cancer Society, or the American Heart Association.

**Q10. Are there any recommendations for community service organizations to implement evidence-based programs to their services? If so, where and how can we recommend?**
A: For advice on implementing evidence-based programs, we recommend you contact one of the following organizations:

- Administration on Community Living (http://www.acl.gov/About_ACL/Contact_Us/Index.aspx)
- Stanford Patient Education Research Center (http://patienteducation.stanford.edu/contact.html)
- National Council on Aging's Center for Healthy Aging (http://www.ncoa.org/improve-health/center-for-healthy-aging/contact-us.html)
- Healthy Living Center of Excellence (http://www.healthyliving4me.org/contact-us/)

**Q11. Which mental status exam do you recommend?**
A: There are a number of validated screening tools that can be used but the available tools that are commonly used in geriatrics practice include: the Mini-Cog™, the Mini-Mental State Examination (MMSE), the Montreal Cognitive Assessment (MoCA), and the Saint Louis University Mental Status Examination for Detecting Mild Cognitive Impairment and Dementia (SLUMS). The amount of time available for screening is a factor. Typically, the briefer tools are used as an initial assessment to determine whether further evaluation would be warranted. For additional information, please visit these resources:

- Cognitive assessment in the elderly: a review of clinical methods (http://qjmed.oxfordjournals.org/content/100/8/469.full) (Woodford and George)
- Screening for Cognitive Impairment in Older Adults (http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/cognitive-impairment-in-older-adults-screening) (Lin, et. al)
- Dementia Screening (https://www.alz.washington.edu/NONMEMBER/SPR07/galvin.pdf) (Galvin)

**Q12. What are some of the best practices for coordinating care and information among members of the inter-professional team?**
A: In order to coordinate care most effectively, members of the inter-professional team should understand and appreciate the roles and responsibilities of each team member, including:

- Knowing when referrals to other team members are needed and appropriate; establish common goals for the team;

- Agreeing on rules for conducting team meetings;
- Communicating well with other members of the team, including identifying and resolving conflict;
- Sharing decision-making and execute defined tasks when consensus is reached;
- Providing support for one another, including the development of leadership roles;
- Remaining flexible in response to changing circumstances;
- Participating in periodic team performance reviews to ensure that the team is functioning well and that its goals are being met.

Research indicates that training programs providing education in these essential areas are successful in enhancing the function and effectiveness of inter-professional geriatrics teams. (Source: http://www.americangeriatrics.org/files/documents/Full_IDT_Statement.pdf).

**Q13. June mentioned a shift in nursing home care from government funded to health plan funded. Can you elaborate in terms of how this is being implemented?**

A: One example of where this shift is occurring can be found in a set of CMS demonstration projects (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html) for dual eligible beneficiaries underway in nearly a dozen states. Through these demonstrations, states are integrating the financing and services available under Medicare and Medicaid, which includes long-term services and supports. Nursing home services will be covered under contract with managed care entities (e.g. health plans) instead of directly reimbursed by the state.

**Q14. How is post-acute social work home coaching reimbursed?**

A: The largest current program is the CMS-funded Community-based Care Transitions Program (CCTP) (http://innovation.cms.gov/initiatives/CCTP/), which is a 2-5 year pilot testing the effectiveness of a community-wide approach partnering community-based organizations (CBOs) and hospitals. If successful, this could become a Medicare benefit. Capitated/managed care entities such as health plans and medical/physician groups are another source. Whoever holds the risk for emergency department use and hospitalization will benefit and should be motivated to pay for care transitions interventions that have been proven to reduce utilization. Hospitals themselves have some motivation to pay for this – they now face penalties for having above-average readmission rates (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html) and there are also incentives to reduce readmissions under "value-based purchasing" (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html). In addition, there is a trend toward hospitals taking a stronger role in population health management, especially as they join accountable care-type organizations and health systems (http://www.beckershospitalreview.com/hospital-management-administration/from-treating-the-sick-to-managing-community-health-hospitals-new-role-in-managing-population-health.html).

**Q15. How often do physicians use community services to assist patients?**
A: Physicians commonly refer their patients to community-based services (e.g., home health nursing, disease specific support groups, vision and hearing rehabilitation centers, hospice, etc.). However, many physicians are not aware of the full scope of services available in their community. Specifically the long-term services and supports network.

**Q16. Is the Geriatric Assessments the same as the Medicare Annual Wellness Exam?**
A: The Medicare Annual Wellness exam includes components that are part of the geriatric assessment process. Typically, an Annual Wellness exam would include assessing functional ability, cognitive assessment, a medication review, a home safety assessment, and a review of all clinical providers.

**Q17. Is there reimbursement for physical activity coaching for fall prevention?**
A: We recommend checking with the American Physical Therapy Association (http://www.apta.org/).

**Q18. Can you elaborate on the program to identify cause of adverse drug reaction along with the literature and research supporting home services?**
A: The program is now called HomeMeds (http://www.homemeds.org/). It is a high-level, evidence-based program approved by the US Administration for Community Living for funding under Title III-D of the Older Americans Act. It has been rigorously reviewed and is now one of just a few programs included in the Aging & Disability Evidence-based Programs and Practices site (http://acl.gov/Programs/CDAP/OPE/ADEPP.aspx). There is also an excellent profile with a strong evidence rating from the Agency for Healthcare Research & Quality (https://innovations.ahrq.gov/profiles/care-managers-use-software-aided-medication-review-protocol-frail-community-dwelling).

**Q19. Is enough attention being given to helping seniors reduce isolation and connect with other people?**
A: While the emphasis of clinical geriatric care may often focus on the cellular, organic, or functional mechanisms of illness, it is important to consider the psychosocial context of aging when diagnosing, treating, and managing the health of older adults. Health in adult development and aging is a complex process that must consider the dynamic interplay between biological, psychosocial, and social domains. The older adult's social network is a critical resource for overall well-being, and social isolation is a powerful risk factor for broad declines and mortality. The effect of a social network on an older adult's overall well-being has been extensively studied, demonstrating clear benefits: reduced mortality risks, better physical health outcomes, better mental health outcomes, and reduced risk of ADL disability or decline. The closeness of social relationships is most important; thus, a well-functioning marital or familial relationship—a relationship that provides a person with a confidante—offers the most helpful kinds of support. Dysfunctional close relationships—those characterized by negative and conflict-filled interactions—appear to work in the contrary direction.

**Q20. Is alcohol a significant contributor to falls among older adults?**
A: Roughly 40 percent of adults 65-years-old and older drink alcohol. Those who drink three or more drinks a day or seven drinks in a week can run increased risks of falls, car accidents, and other injuries. For more information, visit the National Institute on Alcohol Abuse and Alcoholism page on special populations and co-occurring disorders (http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders).

**Q21. As a social working providing services within a physician practice (and making home visits), is it possible to bill Medicare for these assessments?**
A: If you are a licensed clinical social worker (or your state's equivalent) you can likely register as a mental health provider and bill within those codes. Medicare recognizes social work mental health services. There are now some new codes out that include Care Coordination after discharge from a hospital that the office can bill for. If the physician group carries risk, it can be the payer. For additional information on these codes, please see this CMS resource (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-tcms.pdf) on billing Medicare for transitional care management services. The National Association of Social Workers (http://www.naswdc.org/) may serve as a further resource.

**Q22. What is a Medicaid waiver?**
A: Under the federal/state Medicaid program, waivers are one of many options available to states to allow the provision of long-term care services in home and community-based settings (HCBS). States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

**Q23. I am a home care provider and am interested in further discussion on the interaction of the social worker/social services approach with home care workers?**
A: Currently there is no requirement that social workers interact with home care or personal care aides; they may be part of voluntary training programs offered to aides. However, the potential of the dual eligible demonstration projects is that plans must have an interdisciplinary care team for every enrollee that includes social workers and, if long-term services and supports are needed, home care workers can be part of that care team. Under the California demonstration, for example, enrollees receiving in-home supportive services (IHSS) may opt to have their personal care worker participate on care coordination teams along with a primary care doctor, nurse case manager and county IHSS social worker. Also, the National Association of Social Workers has standards for practice

(http://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf) in a range of health care settings.

**Q24. Any suggestions as to engaging resistant clients with repeated ED visits, falls, adverse events?**

A: Frequent emergency department visits generally result from chronic disease that is not well managed, insufficient home support, or anxiety. Family may be mobilized to provide more help, depending on their availability. Typically, family education on the client's chronic illnesses is the most effective approach.

**Q25. What is meant by geriatric and is there a span of age with it?**

A: Geriatrics care refers more to the individual's health status rather than to a specific age span. Some 55-year-olds have multiple chronic health problems and can benefit from seeing a practitioner with expertise in managing multi-morbidity and poly-pharmacy. For the most part, geriatricians care for those 65 and older who have multiple, chronic medical conditions; who may be on a complex drug regimens; and who are experiencing multi-factorial geriatric syndromes—conditions that do not fall into a specific disease category—such as falls, delirium, incontinence, and frailty.