Q&A FOR GERIATRICS-COMPETENT CARE WEBINAR SERIES
Webinar 2: Geriatric Assessment

Q1: Please discuss a normal gait speed again.
A: Fifty feet within 20 seconds would be 2.5 feet/second and 2.5 ft/sec is equivalent to about 0.8 m/sec. A gait speed lower than this would be considered abnormal.

Q2: Are any of the cognitive screening tools recommended or not recommended for a population with serious mental illness?
A: The same cognitive screening tools can be used in patients with mental illness. When interpreting results, it is just important to recognize that mental illness such as depression may be impacting a patient's performance.

Q3: How do you control for lack of self-reflection or denial of mistreatment, substance abuse, and/or depression?
A. It may not always be apparent during an initial visit that there are underlying issues. However, through ongoing care management, issues often become apparent and can then be addressed.

Q4: For people with disabilities, when do you recommend that the conversation about Advance Directives take place?
A: There is no single best time for discussion on advance directives to take place, but most disability-competent organizations include a question or section regarding advance directives in the initial and recurring assessments. For more information on advanced directives for people with disabilities see the Disability-Competent Care Self-Assessment Tool (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DCCAssessmentTool.pdf).

Q5: How often do medical providers integrate with social workers and other community based organizations to perform social assessments?
A: This type of integration is happening more frequently. For example, it is a goal of the financial alignment demonstrations (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html) to integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. In states using a capitated model, each health plan under contract with the state and CMS will have a care manager and an interdisciplinary care team for enrollee that includes medical, behavioral and other professionals on the team. In Ohio, for instance, the state requires plans to contract with the Area Agencies on Aging to conduct the assessments for enrollees over age 60 getting Medicaid home and community-based waiver services. These assessments are the basis for the consumer's care plan.

Q6: Why bedside commode for patient E.L. mentioned in the presentation, it appeared that she did not have ambulation issues?

A: This patient did have gait instability. The therapist who evaluated her home felt that a bedside commode was warranted, possibly due to the layout of her home environment.

Q7: I understand gait being a predictor of disability but could you elaborate on its predictor in death.
A: Gait speed is a strong predictor of mortality. See, Gait Speed and Survival in Older Adults. Studenski S, Perera S, Patel K, et al. JAMA. 2011;305:50-58. Available at: http://jama.jamanetwork.com/article.aspx?articleid=644554.

Q8: How do you approach assessment when English is not the primary language?
A: It is very important to try to do cognitive screening in the patient's primary language to get the best results. I would try to obtain in-person translator services as the first step.

Q9: What do you recommend if the individual has poor speech intelligibility?
A: It may be helpful, with the individual's consent, to include family members or friends during the assessment process. Written responses or tools that include pictures may also be an option.

Q10: What is your follow-up if the patient fails the cognitive screen?
A: If someone fails the rapid cognitive screen, one of the more comprehensive cognitive assessments, such as the Montreal Cognitive Assessment (MoCA) (http://www.mocatest.org/), should be completed.

Q11: Are health systems providing new levels of resources to the CBOs, knowing that additional investment in supports (e.g., buy an air conditioner, remote patient monitoring devices) can reduce ED visits and hospitalizations?
A: Under a capitated health plan model, plans have the flexibility within their reimbursement rates to invest in non-medical services that provided needed support to the enrollee. One example of this is the PACE program, the Program of All-Inclusive Care for the Elderly, which coordinates and provides all needed preventive, primary, acute and long-term services and supports so that nursing home-eligible older adults can continue living active lives in the community. Similarly, health plans participating in capitated model demonstration projects have significant flexibility to provide a range of community-based services as alternatives to or means to avoid high-cost traditional services. In the Massachusetts demonstration (http://www.mass.gov/eohhs/consumer/insurance/one-care/), plans contract with CBOs to serve as Independent Living-Long-Term Services and Supports Coordinators. These Coordinators assess enrollees' needs, help them develop the long-term services and supports component of their care plans and serve on their interdisciplinary care teams.

For additional information about innovative ways that Medicaid is paying for these services, see Medicaid Funding of Community-Based Prevention (http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf): Myths, State Successes Overcoming Barriers and

the Promise of Integrated Payment Models.

Q12: Who ideally is completing the screening process?
A: Ideally, a geriatric assessment is conducted by an inter-professional team. Depending on the individual, this could include a social worker, occupational therapist and/or physical therapist, nurse, nurse practitioner or physician assistant, pharmacist, family caregiver, or geriatrics care manager.

Q13: Where can I obtain the short form-36 Health survey (SF-36)?
A: We recommend visiting SF-36.org (https://www.optum.com/optum-outcomes.html), where you can find the short form-36 health survey, scoring manual and other support materials.

Q14: What are the physician thoughts regarding advance care planning that is done at a much earlier age rather than waiting until the patient is elderly?

A: Many geriatrics practitioners support advance care planning conversations early. Discussions should continue as the individual's health status and situation changes. The more detailed advance care plans and end-of-life care guidance can be, the better. For good resources on this topic, visit The Conversation Project (http://theconversationproject.org).

Q15: Mental health and substance use disorder (SUD) in our society is often referenced as an epidemic, would you comment on this in respect to our aging society?
A. With respect to assessing for depression and substance use disorder, we do see differences among generations of older adults. For example, the very old are less likely to admit to depression or the need for counseling (there is a stigma attached) and are less likely to have used illegal drugs. The young old (people in their sixties) are much more likely to have used recreational or illegal drugs when they were younger and are more likely to continue to use alcohol and illegal drugs as they age. The young old are also more likely to admit to the need for mental health services for depression and other disorders.

Q16: Would you say more about the concept of "life space"? It is being used to assess physical mobility, but I'm inquiring about older adults who may constrain their use of space for psychological or emotional reasons?
A: The concept of "life space" refers to the space that patients move in the community and helps measure one's mobility. However, you are correct that there may also be psychological reasons that an individual's space may be limited. These factors should be considered.

Q17. How would you incorporate a patient's arthritis or pain issues walking in regards to their gait speed? For example if they cannot complete the length in < 25 seconds? Is it still a predictor?
A. Yes, gait speed is a robust predictor of care needs, regardless of the underlying pathology.

Q18. Do you have a preference using one cognitive assessment tool over another (e.g., MMSE, MoCA, RUDAS, AMT)?

A: There are a number of validated screening tools that can be used. 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)