Geriatric Services Capacity Assessment

Domain 3 – Comprehensive Long-term Services and Supports

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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.

3 COMPREHENSIVE LONG-TERM SERVICES AND SUPPORTS

Long-term services and supports comprise the range of home- and community-based services and supports that enable a consumer to reside in his or her home and participate in the community. Assessment of comprehensive LTSS involves the identification of functional capabilities and the prioritization and allocation of resources. This commonly requires investing in resources and equipment to support the health and well-being of the consumer, which, in turn, may prevent avoidable episodes of illness or progression of illness. The sections in this Domain focus on formal, paid care; refer to **Domain 5 – Caregiving**, for self-assessment on informal care.

3.1 Mobility Equipment, Home Modifications, and Supplies

Geriatric capacity includes the ability on the part of the provider and/or organization to respond to equipment needs as soon as possible depending on medical need. Equipment failure or breakdowns impair a consumer's ability to function and can put him or her at risk for secondary health complications such as skin breakdown.

3.1.1 Are consumers assessed to identify services and equipment needs to maximize independence?

Many organizations with geriatric expertise have occupational, physical, and speech therapists perform home- and community-based functional assessments as well as consumer education and training for the appropriate, safe, and effective use of equipment.

3.1.2 Do consumers have access to customized equipment and equipment modifications based on their needs and goals as described in the IPC?

Examples of equipment and modifications include:

- Wheelchairs, scooters, canes, and walkers
- Wheelchair seating and positioning supports
- Communication equipment
- Respiratory equipment
- Bathroom grab bars
- Doorway widening
- Ramps

3.1.3 Is there an adequate network of equipment providers to ensure choice and timely access to needed services?

Due to the importance of equipment and supplies, many consumers may have preferred providers with whom they already have a relationship and who are best able to meet their individual needs.

3.1.4 Are repair requests for durable medical equipment addressed in a timely manner so as not to disrupt or limit the daily functioning of the consumer?

Timeliness of repair requests will vary depending on the equipment (e.g., respirator and cushioning malfunctions vs. a cooking or hygiene aide).

3.1.5 Are back-up options in place for all essential equipment and supplies?

Ensure access to loaner equipment (such as wheelchairs) and same-day delivery of necessary supplies. Some organizations with geriatric expertise have found it best to provide a manual back-up wheelchair for all consumers who routinely use a power chair.

3.1.6 Is there a review process for consideration of assistive technology and other equipment that may facilitate functional independence but is not a specified benefit or service?

Ideally, resource allocation resides with the IDT and the consumer, and they assess the benefit vs. cost. For example, providing a means for a consumer to drain his or her own leg-bag can reduce reliance on PCAs.

3.2 Personal Assistance

Consumers dependent in ADLs and/or IADLs may want access to personal care attendants within their individual or shared living settings. These assistants are provided either by an agency (agency model) or employed directly by the consumer (self-directed or participant-directed model).

3.2.1 Are consumers given a choice between an agency model and a self-directed model for their personal care attendants?

Most Medicaid programs require that consumers be able to choose a self-directed option for PCA services and other LTSS. However, these self-directed options may not exist in every state and/or may be different from one state to the next.

3.2.2 Are consumers able to maintain access to existing or preferred PCAs?

Many organizations with geriatric expertise maintain an open network model or the option for an existing PCA to move to a contracted provider.

3.2.3 Is there a specified transition plan developed prior to a change in PCA service or model of care?

Since PCA services are so important, any gap in service can be problematic.

3.2.4 Is the consumer's IPC available to the PCA (and other caregivers, as appropriate) to direct the delivery of his or hert the delivery of tn theirherert the assessment(s). personal care on a daily basis?

If the consumer employs his or her own personal care attendant, it is important that the PCA is coached on how to use the consumer's IPC to guide the PCA in providing optimal care.

3.2.5 Are all home-based PCAs trained to deliver services and supports based on the consumer's IPC?

Many organizations with geriatric capacity provide training materials for both consumers and their caregivers/assistants to support communication and clarity of roles and expectations. Training materials include specific geriatric competencies (e.g., communication skills with older adults, skin care, positioning and transfer techniques, person centered care, and working with consumers and families with dementia).

3.2.6 Are IDT staff trained to watch for and report problematic home-based relationships, such as abuse, neglect, and exploitation?

In addition to watching out for problematic interactions and relationships, staff must be trained to respectfully address any concerns with the consumer and others as appropriate. State and

federal requirements require certain professionals with geriatric expertise to report abuse and neglect in the case of a problematic caregiver relationship.

3.2.7 Do all consumers have emergency and caregiver back-up plans?

These plans have two components: 1) actions to take if an emergency (fire, electrical failure, severe weather) occurs, and 2) plans for coverage if a PCA or other caregiver is unexpectedly unavailable (alternative caregivers, respite care).

3.3 Self-directed Option for Home- and Community-based Services

The self-directed model of care allows the consumer to design and direct his or her own community-based support services using a defined annual (or monthly) budget. These commonly include personal care attendants, day activities, homemaker services, and other services. For more information on Self-Directed Services, visit Medicaid.gov.[1]

3.3.1 Does the self-directed option allow consumers to be responsible for hiring, firing, training, and supervising personal assistance workers?

The self-direction option often includes recruiting, interviewing, setting or negotiating work schedules and tasks, and evaluating job performance. To promote continuity of care, many geriatric-competent organizations consider allowing consumers to continue with any supports they have had in place prior to their enrollment with the health plan but ensure resources are available to the consumer in managing their employee.

3.3.2 Is skills training and support provided for consumers choosing the self-directed option?

The skills training should include:

- PCA recruitment
- Hiring
- Training
- Direction and supervision
- Emergency back-up plans
- Preventing abuse and neglect

3.3.3 Is a fiscal intermediary or co-employment agency available to support the employer functions of the consumer, if needed?

In some states, participants may also have decision-making authority over how the Medicaid funds in a budget are spent. Fiscal intermediaries assist consumers by conducting payroll functions such as calculating hours and wages, making benefit and payroll tax deductions, and providing paychecks. The intermediary may also assist in the purchase of goods and services to reach a consumer's goals (e.g., assistive technology, home modifications, laundry services, and wellness supports). It will be important for staff interacting with the consumer to understand that how fiscal intermediaries are used, and who performs this function, varies from state to state. For example, if managed care is involved, a state will sometimes have the managed care organization act as the fiscal intermediary, whereas in other states, there will be a separate entity performing this function.

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[1] Access the Medicaid.Gov Self Directed Services page at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html.

3.4 Agency Model

Alternatives to self-directed home and community based services involve contracting with an agency for home-based care. In this model, the consumer enters into a contract with a business that employs PCAs to provide care in the consumer's residence.

3.4.1 Does the consumer have a reasonable choice of providers?

Autonomy and choice are at the core of consumer-centered care and relationships. It is important, as well as mandated, to offer as wide a choice as possible.

3.4.2 Does the agency assume responsibility for orientation, training, and ongoing supervision of a consumer's direct care workers?

While the consumer interacts with the direct care worker on a daily basis, he or she must also have access to the direct care worker's supervisor to address issues and concerns as they arise. Ideally, personal care assistants receive training in geriatric-specific topics, including person-centered care and care of persons with dementia or mild cognitive impairment.

3.4.3 If they are not directly involved with the IDT, are direct care workers and/or their supervisors included in interactions with the IDT?

Direct care workers commonly are a rich source of information and perspective regarding the consumer. With the explicit approval of the consumer, geriatric care plans often involve care managers and direct care providers in the assessment and care planning process.

3.5 Transportation Services

Assess the consumer's medical, social, and vocational transportation needs. If the consumer can no longer drive his or her own vehicle, accessible public transportation may be a cost-effective option for routine or social travel, while individualized and supported transportation may be required for medical appointment or care.

3.5.1 Are the specific transportation requirements of the consumer identified as part of the initial assessment?

The assessment includes physical as well as communication and cognitive requirements. The consumer's IPC should specify the type of equipment and assistance that is needed while being transported.

3.5.2 Is there a range of types of transportation services available to consumers?

Types of transportation services may include:

- Ambulance
- Taxi
- Paratransit services[2]
- Accessible public transportation
- Privately owned vehicles

The IDT will want to understand that the payment for transportation varies from state to state related to Medicaid covering these expenses. Often, creative solutions need to be implemented to pay for transportation needs, such as exploring city programs that reimburse a driver assisting an elderly person or religious organizations responding to a specific request.

3.5.3 Is transportation scheduling support available for consumers?

Organizations with geriatric capacity ensure the consumer understands how to access transportation for all needs (daily as well as episodic and urgent). Support for scheduling is often provided by a designated IDT member, by consumer services staff, or other support staff.

3.5.4 Are transportation services available 24/7 to meet urgent needs?

Outside of regular office hours, only ambulance transport is generally available. In addition to the cost of ambulance transport, most wheelchair users are transported on a gurney and therefore do not have their wheelchair for use in the next setting. Individuals can acquire skin breakdowns while waiting in an emergency department on a gurney or in an ill-fitting wheelchair. Geriatric providers work proactively with consumers to identify back-up plans to address urgent needs.

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[2] Paratransit is a door-to-door transport service available to individuals with disabilities who are unable to ride fixed-route public transportation due to accessibility barriers.

3.5.5 Are there clear policies regarding transportation assistance to health care appointments?

Organizations with geriatric capacity establish clear policies for the provision of transportation services, including authorization guidelines, availability, timeliness, payment, and related arrangements. Transportation is a critical challenge for Medicare-Medicaid enrollees as Medicaid benefit coverage varies between states.

3.5.6 Are transportation providers monitored to ensure safe, dependable, and accessible service?

Transportation vendors should be monitored for professionalism, timeliness, safety, dependability, and accessibility when working with consumers. For example, specific considerations should be made to ensure that vendors understand the difference between curb-to-curb and door-to-door transport, as well as why that distinction is important for consumers. The best source of provider performance is often consumers themselves; consumers should be asked to periodically provide feedback on transportation providers. Many organizations with geriatric expertise also choose to review any injuries that occur during transit.

3.6 Network Composition and Capacity

LTSS includes, but is not limited to: in-home supports, skilled nursing, personal assistance, durable medical equipment and supplies, home health, home-delivered meals, home chores, adult day health, community-based transportation, housing, and social programs. LTSS may also include mental/behavioral health services, recovery support, assistive technology, transitional care and wellness programs.

3.6.1 Are individual home- and community-based supports identified as a part of the assessment and care planning process?

The consumer's goals and priorities, as identified in the assessment and care planning process, must drive the development of his or her community-based support plan.

3.6.2 Are consumers able to maintain existing relationships with LTSS providers?

Continuity of care with LTSS providers is a cornerstone of geriatric capacity. If a consumer's previous provider is not in the network, organizations with geriatric capacity may provide an option to use the out-of-network provider for a determined period of transition.

3.6.3 Is there adequate network capacity to ensure the consumer has access to the full range of needed LTSS?

Organizations with geriatric capacity may consider hiring or contracting with LTSS providers or community providers. LTSS network capacity has not historically been the role of the primary care provider. However, as the movement towards Patient-Centered Medical Homes (PCMH), Health Homes (HH), and Accountable Care Organizations (ACO) continues, there will be an increasing need for partnering, collaboration or integration with the LTSS network and care management organizations.

3.6.4 Is there capacity to develop specific services not readily available in the community that are specified in the individual's IPC?

If the local community lacks any specific services required by the consumer, organizations engage other community-based organizations or social agencies in developing the needed services. Examples may include working with a home care agency to add homemaker services or with local churches to start a food pantry.

3.7 Employment Supports

Employment, whether volunteer or paid, is often an integral component of an individual's health, wellness, and independence. Many Medicare-Medicaid enrollees may depend on part-time jobs to support themselves, despite health problems and/or functional limitations.

3.7.1 Do employed consumers (or those desiring to be employed) have access to services and supports needed to maintain employment?

These supports may include transportation to and from their work or accommodations for rest periods during a shift.

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

3. Comprehensive Long-term Services and Supports

- **Long-Term Services & Supports:**
  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Long-Term-Services-and-Supports.html
- **Home & Community Based Services:**
  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html
- **Eldercare Locator:**
  http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx
- **Long-Term Care: Home-Based Services:**
  http://nihseniorhealth.gov/longtermcare/homebasedservices/01.html

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.