

**GERIATRIC SERVICES
CAPACITY ASSESSMENT**

**DOMAIN 8 - GERIATRIC
ASSESSMENT**

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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.

8 GERIATRIC ASSESSMENT

Elderly Medicare-Medicaid enrollees deal with a vast array of chronic health conditions and often multiple, co-occurring health conditions. In order to effectively and efficiently meet their needs, providers should incorporate Comprehensive Geriatric Assessment into their protocols.

Consumer-centered care necessitates an approach in which the individual is fully incorporated into decisions. This is not as simple as just asking for his or her input but rather, encouraging and facilitating a person's initiation of areas of concern. It is particularly important to understand the goals, values and preferences of the older consumer. For example, for some older adults, fear of death is less than the fear of becoming dependent on others for daily care needs, fear of being a burden on family or fear of needing to move to residential or institutional care.¹ Geriatric-competent providers evaluate interventions and decisions not to intervene in terms of the impact on potential loss or gain of independence, the impact on quality of life as defined by the older adult and the trade-offs required by a particular intervention.

Providers who provide care for older individuals keep the principles of geriatric assessment at the forefront of their practice:

- **Goal:** Promote wellness, independence
- **Focus:** Function, performance (gait, balance, transfers), independence, trade-offs
- **Scope:** Physical, cognitive, psychological, social domains
- **Approach:** Multidisciplinary
- **Efficiency:** Ability to perform rapid screens to identify target areas
- **Success:** Maintaining or improving quality of life

¹ Brummel-Smith and Gunderson. (2007) Caring for Older Patients and an Aging Population. In Ham et al. (eds), *Primary Care Geriatrics*, 5th edition, pp. 8. Philadelphia, PA: Mosby Elsevier.

8.1 Assessment and Approach

When interacting effectively with an older person, it takes time and a visibly open demeanor on the part of those who are present. Take the time to introduce yourself, sit at eye level, face the person, and speak slowly. Practitioners in the field of geriatrics call this “slow medicine”. In geriatric medicine, acting hastily is more likely to do harm than not acting at all. Care decisions need to be paced so the older person, the family and the clinician have time to evaluate options before proceeding. Providers will gain much insight when shifting from formulaic assessments to participatory assessments. Complete body system assessment may still be accomplished if necessary but perhaps not in a head-to-toe numeric order. Rather, the process follows the lead of the older consumer as he/she shares what is needed. The practitioner can also ensure a targeted rapid screening to ascertain what else may be an unrealized need of the consumer which is discussed more thoroughly in 8.4 below. Providers that serve geriatric consumers take special care to ensure their environments and assessments are welcoming, comfortable, and accessible for all.

8.1.1 Are clinical environments accessible to geriatric consumers?

Geriatric consumers are more likely to have functional disabilities; therefore, it is necessary that office environments are easily accessible. An accessible environment will include ample handicapped parking, automatic doors, and wide-open hallways. Offices on multiple levels should also have elevators, ramps, and/or lifts. Likewise, examination and treatment rooms should be easily accessible by being closer to the waiting room so the person does not have to walk a distance and have a wide door in case a companion is assisting the individual to walk. Organizations with geriatric expertise provide training for their staff in geriatric assistance. For example, office and medical assistants are trained to provide assistance when walking or moving onto an exam table, when necessary. This can also include how to speak to older adults in a helpful and professional manner. Other ways to ensure the environment is accessible for all consumers include:

- Parking for persons with disabilities and a designated drop-off area
- Availability of chairs and wheelchairs in the lobby area
- Family bathroom nearby
- Accessible bathroom for persons with disabilities nearby
- Multiple chairs in the examination room to accommodate family members or caregivers

8.1.2 Are clinical environments comfortable for geriatric consumers?

Clinical environments serving geriatric consumers should be free of loud music, clutter, and other distractions. Geriatric-competent providers create a comfortable environment for consumers by providing reading materials that would be of interest to older individuals and comfortable seating that can accommodate a wide range of functional capabilities. For example, providing a chair with arms facilitates the individual being able to push him- or herself into a standing position. Providers also attempt to make treatment and examination rooms as comfortable as possible, possibly by keeping them a little warmer or having a blanket warmer in case someone is cold.

8.1.3 Can providers manage geriatric cross-cultural interactions?

If a provider is not familiar with a consumer's culture, community or ethnic background, the provider may need assistance from a person who acts as a cultural guide. This is a bilingual or bicultural person who has a solid understanding of both the consumer's culture and the health care culture. Providers will benefit also by asking the consumer about his or her culture in an effort to reach a greater understanding. If done with sincerity, this direct inquiry is not only very effective in learning about another's background; it promotes trust between the consumer and the person asking, as well.

8.1.4 Do providers strive to gain the trust of the older consumer?

Demonstrating respect and cultural appreciation are the cornerstones of developing a trusting relationship with an older consumer. A provider or person interacting with an older person will not go wrong by greeting the geriatric consumers first when someone else accompanies them and using the appropriate prefix (Mr., Mrs., Dr., etc.). All of us appreciate some informal conversation before starting an assessment or procedure. These actions tell the person he or she is an individual and not a task to be accomplished. When an older person has hearing deficiencies or cognitive limitations, many people talk to the person's companion as though the individual were not present. It is essential to continue to address the geriatric consumer directly, and know that their friend or family member will provide answers if the consumer cannot.

An additional aspect of gaining and maintaining the trust of the older consumer is openness and clarity about the consumer's rights under HIPAA Title II to obtain, share, and request corrections to their health record. See question 7.2.4 for more information on the role of HIPAA in an organization with geriatric capacity.

8.1.5 Can providers select an appropriate interpreter if necessary?

In the 2000 census, 38% of Hispanic/Latino elders and 41% of Asian elders indicated that they speak little or no English.² If these populations continue to grow in the United States, geriatric providers will need to use interpreters more frequently. Untrained interpreters are to be avoided wherever possible. Use of family members as interpreters may create risks of potential conflict of interest, limited language skills to facilitate interpretation, and/or culturally-based barriers. Yet, there are times when this is necessary and there are situations where it is culturally-appropriate to include the family member. Geriatric providers maintain a list of available on-site and telephonic interpreters. Competent providers incorporate interpreters into the care team. It is important that all interpreters understand their role in conveying the exact words or intent of the speakers and not interject their opinions or observations during interpretation.

² Stanford University. Ethnogeriatric Curriculum Module. Retrieved from <http://web.stanford.edu/group/ethnoger/hispaniclatino.html>

8.1.6 Do providers use respectful and appropriate non-verbal communication?

Most interpersonal communication is nonverbal. Nonverbal communication can aid in fostering trust and developing a rapport with geriatric consumers. People of different ages and backgrounds may use nonverbal communication differently. Providers need to be mindful and take careful consideration when using the following forms of communication:

- **Body Movement:** Gestures, movements, and handshakes can be misinterpreted based on a consumer's cultural background. Check with an interpreter or cultural guide if you are unsure.
- **Touch:** The etiquette of touch varies greatly across cultures. Geriatric providers need to understand the norms for cultures with which they work.
- **Eye contact:** Most Americans consider it respectful to look someone in the eye when speaking; other cultures consider this disrespectful. Observing consumers upon first meeting them will provide clues as to what is appropriate.
- **Physical distance:** Geriatric consumers from some cultures may prefer to be close in proximity to the provider; others may prefer to be farther away. The provider should always give consumers a choice by asking them where they would like to sit.

8.1.7 Are providers capable of conducting an ethnogeriatric assessment?

An ethnogeriatric assessment involves consideration of background and contextual topics when conducting a medical assessment of a geriatric consumer. It is in the best interest of the provider and the consumer to be keenly aware of a consumer's ethnicity, religion, sexual orientation, communication behaviors, decision-making behaviors, and level of acculturation, and how these characteristics may impact a consumer's care plan.

8.1.8 Do providers conduct family assessments?

An understanding of a consumer's family life and background is critical to the holistic view of the consumer. When conducting a family assessment, providers need to consider the family's composition and structure, gender roles, decision-making patterns, kinship and social support, connectedness, community characteristics, and neighborhood safety and accessibility.

8.1.9 Do providers conduct home assessments?

Geriatric providers will want to understand a consumer's home environment as it will play a role in a person's care plan. When assessing a consumer's home environment, a provider needs to consider the home's residents and their relationship to the consumer, available support, safety, comfort, economic stability and adequacy.

8.1.10 Are providers sensitive to cultural differences when conducting physical exams?

A geriatric consumer's comfort with a physical exam will vary based on that person's culture, background and personal preferences. Always ask if the consumer would prefer to have a family member present and always ask for permission before examining different parts of the

body. Providers need to inform the geriatric consumer of the procedures before beginning, in the interest of reducing anxiety. It is important to keep in mind that physical examination by someone of the opposite sex is unacceptable in certain cultures.

8.1.11 Do providers assess and discuss end-of-life preferences?

For some cultures (and for some people, regardless of culture), a discussion of death is overwhelming and may even be inappropriate. Providers must approach this issue with caution and sensitivity and only after a trusting relationship has been established with the geriatric consumer. A conversation about end-of-life preferences includes a discussion of advance directives, organ donation, autopsy, death rituals and mourning behaviors, and preference for end-of-life care.

8.2 Conducting Assessments and Screening Tools

Conducting assessments and using screening tools are routine practices for all providers and consumers. The purpose of this section of the self-assessment is not to recommend a specific assessment or even to give an exhaustive list of components to be covered during an assessment. There are many tools and checklists readily available on the internet for the practitioner to use. Rather, the value of this part of the self-assessment for geriatric competency is for readers to look at their general preparation and capacity to determine what the older individual needs. Practitioners serving geriatric consumers will want to consider conducting rapid screening assessments on individuals before a complete assessment. This approach assists the provider to focus on those areas that are most likely to need further assessment and, by so doing, minimizes the impact of a thorough exam on the energy of the older person. Team members can be utilized to conduct the rapid screening. A problem identified in any of the following seven areas triggers a more thorough assessment:

1. Functional status including activities of daily living and independent activities of daily living
2. Mobility and fall risk (e.g., the timed “Get up and go” test and Life-Space test)³
3. Nutrition (unintentional weight loss in prior six months)
4. Vision (if unable to read newspaper headline while wearing corrective lenses)
5. Hearing (acknowledged hearing loss when questioned or unable to pass “whisper test” of two feet)
6. Cognitive function (e.g., three item recall after one minute or Mini-Cog)⁴
7. Depression (Do you often feel sad or depressed?)

In addition, team members would focus on case-finding for conditions and syndromes that may be undetected in older adults. These may include: pain, prior fractures, osteoporosis, urinary incontinence, behavioral changes, dizziness, sleep disorders, alcoholism, skin breakdown, sexual dysfunction, macular degeneration, cerumen impaction, stroke, polymyalgia rheumatica, temporal arteritis, Parkinson’s disease. Questions about social support, financial concerns, environment and living situation, goals of care and advanced care preferences are also part of the geriatric assessment.

Consumers with multi-domain challenges may benefit from referral to a geriatrician, geriatric advanced practice nurse or geriatric team for more comprehensive assessment, planning and geriatric expertise. Geriatric-competent organizations are aware of some of the challenges that impact primary care and illness care related to aging including:

³ Life Space tests are a measure of movement through one’s environment, as one aspect of environment complexity for an individual. It measures the frequency, extent, and independence of a person’s movements inside and outside of their home environment. Crowe, M., Andel, R., Wadley, V.G., Okonkwo, O.C., Sawyer, T., Allman, R.M. (2008). Life-Space and Cognitive Decline in a Community-Based Sample of African American and Caucasian Older Adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 63(11), 1241. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2820830/>

⁴ Routine assessment of cognitive function remains a key step for early detection and diagnosis of Alzheimer’s disease. The Medicare Annual Wellness visit was initiated in January 2011 as part of the Affordable Care Act. The yearly Medicare benefit includes the creation of a personalized prevention plan and detection of possible cognitive impairment.

- Non-presentation when ill
- Modified or nonspecific or atypical presentations of illness
- Multiplicity of problems with likely multiple causes for each problem, e.g., geriatric syndromes
- Importance of habilitation and rehabilitation
- Polypharmacy
- Iatrogenesis
- Modified speed of recovery
- Interaction between individual and the environment⁵

8.2.1 Are assessment tools and forms appropriate for geriatric consumers of all educational levels?

Any written assessments or intake forms use language that is appropriate for consumers of all educational levels. Simple response formats such as 'yes/no' or 'true/false' are also more appropriate for consumers of all educational backgrounds.

8.2.2 Are assessment tools and forms appropriate for geriatric consumers with visual impairment?

Any text that a geriatric consumer is required to read needs to be printed in 14 or 16 point font. To accommodate visual impairments, text documents use fonts with easily recognizable characters, either standard Roman or Sans Serif fonts (such as Arial) and avoid decorative fonts. Using bold type can make the print more legible; however, italics or using all capital letters can make it more difficult to differentiate among letters.

8.2.3 Are translated materials available and adequate?

If geriatric providers frequently work with consumers who speak little or no English, and if consumers will be required to read for assessments or intake, translated materials need to be made available. The adequacy of translated materials depends on the equivalence of content, semantics, criterion, and technical methods.

8.2.4 Do providers make use of culturally-appropriate assessment measures?

Certain geriatric assessment measures have been designed specifically for use across different cultures and languages. For examples, the Geriatric Depression Scale (GDS) has been translated to 30 different languages and has undergone rigorous validation testing. The Spanish and English Neuropsychological Assessment Scales (SENAS) were developed to allow providers to measure the cognitive capability using equivalent Spanish and English assessment domains. The Cognitive Assessment Screening Instrument (CASI) and the Cross-Cultural Neurophysical Test Battery (CCNB) are other examples of instruments designed specifically for cross-cultural functionality.

⁵ Steinweg, K. (2007). Initial Assessment. In Ham et al. (eds), *Primary Care Geriatrics*, 5th edition, pp. 8. Philadelphia, PA: Mosby Elsevier.

8.3 Appropriate Prescribing

The American Journal of Geriatric Pharmacotherapy suggests that up to 60-80% of geriatric individuals are taking five or more medications.⁶ Geriatric Medicare-Medicaid consumers are even more likely than their other geriatric counterparts to be taking numerous drugs. The likelihood of an adverse drug event (ADE) increases as the number of drugs prescribed increases. Geriatric consumers are also more likely to experience ADEs as a result of comorbidity and aging. For these reasons, providers serving geriatric consumers are acutely aware of each medication that is prescribed and the impact of that medication on an individual's care plan and overall health.

8.3.1 Do providers consider age-related body changes and comorbidities when prescribing?

Geriatric providers need to take special circumstances into consideration when prescribing to consumers. Providers should first consider how a consumer's body composition, central nervous system, and renal and hepatic function may have changed as a result of aging. Medicare-Medicaid consumers are more likely to present with comorbidities and limited functional capability. These circumstances must be considered when prescribing appropriately.

8.3.2 Do providers take necessary precautions to avoid adverse drug events?

Special precautions should be taken when prescribing drugs that present a high risk for ADEs or interactions with other drugs. When prescribing these drugs, providers must discuss the potential side effects and interactions, and ways in which the consumer can limit the negative impacts on their health. Medications with a narrow therapeutic window require more frequent monitoring and attentive consumer education to enhance self-management and reduce risk for adverse drug events. Geriatric dosing requires expertise in drug initiation, dose titration, dose tapering, discontinuation, and modification based on aging changes, liver and renal function, and increased sensitivity to neuropsychiatric side effects. Geriatric providers also educate consumers about potential risks related to over-the-counter (OTC) preparations. Geriatric providers recognize transitions in care as high-risk times for adverse drug events and use strategies to reconcile medicines, educate consumers and supporters, and make referrals for care transition services and contacts, where appropriate.

8.3.3 Are providers familiar with the most current Beers criteria?

The American Geriatrics Society (AGS) regularly updates and expands the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. This criterion is a leading source for information about the safety of prescribing drugs to geriatric consumers and identifies medications with risks that may be greater than their benefits for people over the age of 65. Drugs are classified in one of three categories: drugs that should always be avoided, drugs that are potentially inappropriate in consumers with particular conditions, or drugs that are used

⁶ Atkinson, H., & Shimomura, S. Medication Management Competency. Retrieved from http://www.americangeriatrics.org/files/documents/annual_meeting/2013/handouts/sunday/U1230-5514_Hal_H_Atkinson.pdf

with caution. Some of the Beers Criteria medications are found in OTC remedies and geriatric providers educate consumers about these medicines.

8.3.4 Do members of the IDT routinely review a consumer's medications?

Because care plans and conditions of geriatric consumers can change frequently, geriatric providers, and the IDT as a whole, should make it a habit to routinely review a consumer's medications. The review incorporates all medications prescribed by the general practitioner and other specialists, as well as any OTC drugs or supplements. When reviewing with the patient, the IDT needs to discuss adherence to the care plan and any duplicate or unnecessary medications. Irrespective of the particular medications involved, providers recognize that the risk for adverse outcomes (e.g., weight loss, falls, non-adherence, drug-drug interactions) increases as the number of medications increase. Geriatric-competent care includes optimizing non-drug strategies and conducting frequent medication reviews. Geriatric experts are consulted to guide appropriate drug weaning and discontinuation since adverse effects may occur if some drugs are stopped abruptly. Geriatric providers are familiar with the Food and Drug Administration guidance regarding risk of mortality if antipsychotics are used for the treatment of behavioral expressions in older adults with dementia.

8.4 Preventative Care

Preventative care is important for all health care consumers, but is particularly important for geriatric Medicare-Medicaid consumers. Preventative medicine may help to reduce the effect of co-morbidities and manage the impact of diseases and disabilities on a person's health. For geriatric consumers, preventive medicine is less concerned with extending a person's life and more concerned with improving a person's quality of life. Geriatric providers are well informed on preventive care procedures and standards for persons age 65 and older.

8.4.1 Are providers aware of which preventative care services are covered under Medicare?

Medicare will cover preventative care services that have been recommended as "Grade A" or "Grade B" by the U.S. Preventative Services Task Force. The Patient Protection and Affordable Care Act waives any deductible or coinsurance for these services. Many preventative services are backed by strong evidence that support their benefit, but are not covered under Medicare. For example, screening for visual or auditory impairment before these disorders manifest likely does not meet the criteria to be covered under Medicare. Under the Patient Protection and Affordable Care Act (2010), Medicare covers the following preventative services:

- One time "Welcome to Medicare" physical exam
- Annual Wellness Visit⁷
- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- EKG Screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV Screening
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Pneumococcal shots

⁷ The March 2010 federal health care reform law, the Patient Protection and Affordable Care Act (ACA), established a new benefit that began January 1, 2011. It enables Medicare beneficiaries to receive an annual wellness visit that focuses on establishing and then maintaining a personalized prevention plan. A beneficiary is eligible if he or she: has had Medicare Part B coverage for at least 12 months; and has not received either an Initial Preventive Physical Examination, known as the "Welcome to Medicare" visit, service or an annual wellness visit service within the past 12 months. Retrieved from http://www.acponline.org/running_practice/payment_coding/wellness_q1.htm

8.4.2 Are providers familiar with the national coverage determination process?

Medicare may cover additional preventative and screening services that are deemed reasonable and necessary for the prevention or early detection of an illness or disability. The criterion is stringent and the approval process can take up to 6 months.

8.4.3 Are providers familiar with the U.S. Preventative Services Task Force (USPSTF)?

The USPSTF was established in 1984 “to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medications”. The task force issues prevention and screening recommendations for over 100 different diseases, disabilities, illnesses, and condition. The task force makes specific recommendations for adults that can be found here:

<http://www.uspreventiveservicestaskforce.org/adultrec.htm>

8.4.4 Do providers recommend annual physical or wellness exams?

Annual physical exams are recommended for adults age 65 and older. However, the provider must take into consideration the extent of this exam related to the consumer’s ability to tolerate any lengthy procedure or testing. Practitioners will want to consider triggers in their medical record systems to call and remind consumers of the need to schedule a wellness exam.

8.4.5 Do providers prescribe preventative OTC medications?

Practitioners will want to stay knowledgeable of the current recommended OTC medications related to prevention, such as low-dose aspirin or vitamin D, and include these medications in their discussions and orders for individuals for whom they are providing care.

8.4.6 Do providers monitor immunization records?

Providers serving geriatric consumers need to regularly monitor records to ensure that their consumers are up to date on their immunizations. The following immunizations are recommended for adults age 65 and older:

- Influenza: one dose yearly
- Hepatitis A: two doses for high risk consumers
- Hepatitis B: three doses for high risk consumers
- Measles/Mumps/Rubella: only for high risk consumers
- Meningitis: only for high risk consumers
- Pneumococcal: one dose
- Shingles: one dose
- Tetanus: one dose every 10 years
- Chicken pox: only for consumers with no history of vaccination

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_Compentent_Care_Webinar_series

8. Geriatric Assessment

- **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
- **Ethnogeriatric Assessment:**
<http://web.stanford.edu/group/ethnoger/hispaniclatino.html>
- **Medication Management:**
http://www.americangeriatrics.org/files/documents/annual_meeting/2013/handouts/sunday/U1230-5514_Hal_H._Atkinson.pdf
- **Geriatric Behavioral Health:**
<http://www.gmhfonline.org/gmhf/>
http://www.iom.edu/~media/Files/Report%20Files/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults/MHSU_olderadults_RB_FINAL.pdf
- **Beers Criteria:**
<http://www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf>
- **Medicare Preventative Care:**
<http://www.medicare.gov/Pubs/pdf/10110.pdf>
- **Annual Wellness Exam:**
http://www.acponline.org/running_practice/payment_coding/wellness_q1.htm
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf
- **Medicare Coverage Determination:**
<http://www.cms.gov/Medicare/Coverage/DeterminationProcess/>
- **U.S. Preventative Services Task Force:**
<http://www.uspreventiveservicestaskforce.org/>

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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.