

**GERIATRIC SERVICES
CAPACITY 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.

1 RELATIONAL-BASED CARE MANAGEMENT

Relational-based care recognizes that the consumer is not merely a passive recipient of medical care, but rather the primary source for defining care goals and needs.¹ This type of care requires cultivating a relationship with the consumer, seeing him or her as a whole person with hopes and preferences, and recognizing that the consumer is often the best steward of resources. Inherent in consumer-centered planning of care goals and needs is also the concept of dignity of risk, which respects the consumer's choices even if they are inconsistent with the recommendation of the interdisciplinary team (IDT). You are encouraged to return to this domain frequently to guide your understanding of the other seven domains.

¹ The term consumer is used in this Tool in place of patient, member, or participant, acknowledging the individual's agency in decisions and interactions.

1.1 Consumer-Centered Practice

The consumer's choices, preferences, and goals provide a foundation for his or her individualized and person-centered plan of care (IPC). The IPC identifies all the care, services, and supports for each consumer. It is a dynamic document, referenced, reviewed, and revised over time, to ensure preventive strategies are in place, and that plans are effective, are being followed, and are based on the consumer's changing needs. A trusting and respectful relationship between the consumer and his or her care team is necessary to ensure decisions for care and services remain consumer-centered.

1.1.1 Do consumers play an active role in their own assessment and care planning?

Consumers commonly need support and coaching about the assessment and care planning process. This support is provided by individuals, including physicians, nurse practitioners, physician's assistants, case managers, home and community based services (HCBS) providers, staff at alternate living arrangement facilities, and others, who are familiar with the assessment and care planning process and understand how it may be daunting and overwhelming. A preliminary "get to know you" meeting can help establish the relationship so that the subsequent meeting can focus on the full assessment and care plan development.

1.1.2 Does staff develop an individualized, professional relationship with the consumer, showing respect for the consumer's preferences and for the dignity of risk?

Developing this trusting relationship generally requires an initial face-to-face interaction and includes discussion of the consumer's goals, values, and preferences for his or her care. This relationship is paced so the consumer, family and clinicians have time to evaluate thoroughly the consumer's needs.

1.1.3 Are older consumers (and families or caregivers) involved in care planning and implementation to ensure a consumer-centered focus?

Organizations with geriatric competency involve the consumer throughout the care planning process and in each step of creating and updating the individualized care plan. Health plans and systems that provide geriatric-competent care have multiple avenues to engage older consumers in care planning and to seek their perspectives and ideas. Consumers provide one of the best sources for performance feedback. They should be asked to periodically provide feedback on their experience of care planning and implementation as well as about the providers of their care. Organizations may need to involve families or caregivers more closely in the care planning process when providing care to consumers with certain conditions (e.g., Alzheimer's disease). Family members and caregivers can help in the recall and understanding of the complete array of symptoms and can ensure appropriate follow-up, either with health professionals or with other resources available in their community. Refer to **Domain 5 - Caregiving** for more information on working with informal caregivers in the care planning process.

1.1.4 Does staff consistently respect and accept the decisions and preferences of consumers?

A consumer may have difficulty identifying or asserting his or her preferences, so the IDT will want to consistently seek his or her perspective and preferences. If a consumer's preference is inconsistent with the IDT's recommendation, the consumer's choice needs to be respected. The IDT will want to discuss the pros and cons of the consumer's preference while advocating for recommended options. It is also important to know when to stop advocating for recommended options so that the consumer does not feel unduly pressured every time he/she seeks care. If the consumer is ambivalent or requests guidance, shared decision-making and decision support should be offered. For consumers with certain conditions (e.g., Alzheimer's disease), it can be difficult to ensure that the consumer understands important information regarding his or her care in order to make an informed decision. This reinforces the need to involve both the consumer and close family members or caregivers at all stages of the care process so that the consumer's wishes can be balanced against the needs of the family, caregiver, and other social supports.

1.1.5 Does the IDT periodically assess how well each consumer understands his or her rights and consumer protections?

Geriatric-competent organizations routinely include this assessment as part of the initial assessment and all reassessments. Staff are trained to be sensitive to any resistance or concerns expressed by the consumers and to remind them of their rights to disagree. The presence of pain, depression, acute illness or hearing loss poses particular challenges to consumer engagement, self-advocacy and decision-making. Geriatric-competent organizations assess for these conditions and enhance consumer support. For consumers with certain conditions (e.g., Alzheimer's disease), pain may manifest itself in different ways, including agitation or other behavior changes, which may further complicate decision-making.

1.2 Eliminating Medical and Institutional Bias

Medical and institutional bias often impedes providers from addressing the whole individual, including his or her unique abilities, limitations, and preferences for social and community participation. Social and community participation may require supports and services for the older consumer to remain in his or her preferred living setting. Care planning needs to consider the right amount of care (not too much, not too little) as well as the right location (least intensive and least restrictive).

1.2.1 Does the IDT help consumers explore all possible options for living in the least restrictive environment of their choice?

When the consumer and his or her IDT determine that the consumer's current residential setting is unable to meet his or her needs, the care team identifies and discusses a range of options with the consumer and the family or caregiver, as appropriate. Since care is usually attached to the residential setting, it is important to offer as wide a choice as possible. It is important, as well as mandated, to offer as wide a choice of living arrangements as possible. It is important to consider locations in choice so that long-time friends and family can easily visit.

1.2.2 Are consumers given a choice of community supports and service providers?

Older consumers may want to understand their options for community-based support, including informal supports rather than paid workers. They may also need education on self-directed models for community supports or a traditional agency/provider model, as well as options for maintaining existing personal care assistant (PCA) relationships. (See 3.2 in **Domain 3 - Comprehensive Long Term Supports and Services** for further information). Additionally, having access to a roster of service and support providers with an evaluation of provider performance will support, foster, and enable consumer choice.

1.2.3 Is the consumer's current living situation re-evaluated prior to planning a permanent transition to a greater level of care?

Many organizations with geriatric competence establish a re-evaluation process that includes considering if adaptations or additional supports could enable the consumer to continue living in his or her current setting. This process seeks to ensure that permanent changes are a choice of last resort.

1.2.4 Are potential ethical conflicts formally reviewed via committee or consultation to ensure consumer autonomy and self-determination?

The aging process has the potential to constitute a significant threat to autonomy as older adults often need to rely on others when faced with functional, emotional or cognitive impairment. Therefore, it is imperative that organizations with geriatric capacity have formal protections in place to ensure that potential ethical conflicts are identified, assessed, and addressed.

1.3 Interdisciplinary Team

Geriatric-competent care is interdisciplinary team-based care with core competencies in primary care, behavioral health, geriatrics, Long-term Services and Supports, and gerontological nursing. Operating in close communication with the consumer and external providers, the interdisciplinary team (IDT) is responsible for ensuring the consumer receives the care and supports he or she needs to achieve his or her goals and maximize independence.

1.3.1 Composition

1.3.1.1 Are the competencies of primary care, nursing, behavioral health, and LTSS represented on each IDT?

The core care team is comprised of staff with competencies in primary care, nursing, behavioral health, and community-based service supports. Primary care practitioners might include physicians, nurse practitioners, or physician assistants. Nursing practitioners might include advanced practice nurses, registered nurses, or licensed practical nurses. Behavioral health practitioners might include social workers, psychologists, chemical dependency specialists, or other comparably trained practitioners. LTSS practitioners might include social workers, mental health therapists, community health workers, or other comparably trained care management staff. Special training in geriatric medicine, gerontological nursing, social work or related disciplines is essential to providing skillful assessment and care and, ideally, one or more members of the team should be credentialed in geriatrics or gerontology (e.g., geriatrician, gerontological advanced practice nurse, geriatric social worker or geriatric care manager). Team care is essential to provide optimal support to the older consumer. No one person has all the information or skill to assess the consumer in a holistic manner or ensure the right care is provided.

1.3.1.2 Are practitioners on the IDT experienced in providing disability-competent care since so many aging persons are also disabled to some degree?

All members of the IDT should either be experienced in working with older adults who also may have a disability or, at a minimum, willing to be trained and coached accordingly. Organizations with geriatric capacity should have extensive training programs for new staff to teach disability sensitivity, awareness, and considerations related to their specific area of practice, including core concepts of geriatric and gerontological practice.

1.3.1.3 Is the consumer's primary language, means of communicating, and ethnic/cultural competencies considered in identifying specific members of the IDT?

While this is not always feasible, having IDT members with these competencies can increase the trust between the consumer and his or her IDT. Assistive technologies and methods to communicate with persons who have expressive or receptive communication challenges should also be considered.

1.3.1.4 Do all IDT members understand their individual roles and responsibilities?

While the IDT collectively shares responsibility for the health and well-being of each consumer, each member of the IDT practices within his or her scope of competency, minimizing redundancy and utilizing support staff when appropriate.

1.3.1.5 Is one member of each consumer's IDT designated as the "lead"?

It is imperative that one team member have final responsibility and accountability for both the IDT and the IPC. Some organizations choose to routinely have the team lead assigned to a specific role (such as the primary care practitioner), while others use a specified collaborative practice model or choose to vary the designation of lead based on the unique needs and/or preferences of the consumer.

1.3.1.6 Are additional resources or consultants available to the IDT based on the specific needs of each consumer?

Additional resources or consultants may include sub-specialty (dental, podiatry, pain management) providers, rehabilitation (OT, PT, speech therapy, etc.), durable medical equipment, nutritional services, and pharmacy.

1.3.1.7 Is the consumer able to designate a family member or close friend to be involved in IDT-related communications?

When a consumer specifies a family member or other person to be involved in IDT communications, this must be documented in the IPC and communicated to all IDT members to ensure consistent follow-through.

1.3.2 Communications

1.3.2.1 Does the IDT meet weekly to discuss relevant consumer updates, new assessments, and reassessment reviews?

Many organizations use structured agendas to ensure the productive use of team meeting time. Meetings can be in-person or virtual. While not every consumer is discussed every week, it is helpful to have system triggers in place to ensure: 1) review of any consumer under acute care, 2) review of any consumer transitioning from one facility to another setting of care whether that is another facility or back into the community residence, 3) discussion of any change in health or caregiver status, and 4) routine, prescheduled reviews.

1.3.2.2 Does the IDT ensure that each consumer's IPC is reviewed at predetermined intervals?

Each consumer should have his or her IPC reviewed at regular intervals (bi-annually, at a minimum), as well as when a new issue or change in condition emerges.

1.3.2.3 *If a consumer maintains a relationship with an external care provider, (a provider outside of the IDT) is there a designated staff member who is the point of contact for the external provider?*

Some older consumers may choose to maintain relationships with other care providers who are not actively involved in the consumer's care. If this is the situation, the lead on the IDT is often designated to be responsible for communicating with the external care provider.

1.3.2.4 *Is the IDT able to meet, either in person or virtually, within 24 to 48 hours if the consumer's needs or situation changes?*

The need for timeliness will vary depending on the urgency of the situation. In some organizations, IDT members maintain flexible schedules to be able to address emerging concerns.

1.3.2.5 *Is the assessment and IPC available to anyone providing after-hours coverage?*

At a minimum, information on each consumer's IPC should be available via fax or encrypted or secure email, but is ideally in the form of a remotely accessible electronic health record (EHR). See section 1.4 for a full description of the assessment(s).

1.4 Assessment

The initial and regularly revised assessment of the consumer's care needs and goals is an interactive process, with the outcome being a comprehensive IPC. The initial assessment provides a key opportunity for the IDT to establish a relationship with each consumer and to build the trust needed for successful, ongoing care and care management.

1.4.1 Is the initial assessment conducted in-person?

Geriatric-competent organizations have found that a key lever to establishing a trusting and respectful relationship between the older consumer and his or her IDT is having the opportunity to meet in person. If an in-person meeting is not possible, video or telephone conversations may be used until the consumer is able to have an in-person meeting.

1.4.2 Are at least a portion of the initial assessment and the periodic reassessments conducted in the consumer's living environment?

Organizations with geriatric competency have found that meeting in the older consumer's living environment often helps overcome barriers to care, including transportation and functional limitations. This also provides the IDT an opportunity to see first-hand where the consumer lives, assess his or her level of function within the home environment, and identify opportunities to increase independence and safety in daily functioning. Some consumers may opt to initially meet their IDT in a venue outside the home. If this is the case, the IDT should work to gain the trust of the consumer so they can be welcomed into the consumer's home to see how he or she functions in this environment.

1.4.3 Are the initial and subsequent assessments attended by all members of the core IDT (see 1.3.1)?

It is important for all members of the consumer's IDT to actively participate in the assessment process, for each team member brings a different set of skills and knowledge.

1.4.4 Is the consumer able to include other individuals in the assessment process?

The consumer may wish to include other individuals such as family members, caregivers, friends, community supports, ministers, ombudsmen, care managers and clinicians such as nutritionists.

1.4.5 Does the assessment process identify additional expertise needed for the consumer's care?

The IDT should incorporate the expertise of other clinicians or care providers as needed, including rehabilitation therapists, behavioral health providers, dieticians, peers, LTSS providers, or specialists (such as geriatricians, gerontological clinical nurse specialists and palliative care practitioners), either on an ongoing or consulting basis.

1.4.6 Is the initial assessment comprehensive and multidimensional, incorporating all aspects of the consumer's life?

Domains to be assessed include:

- Advanced health care decision-making and advanced directives
- Cognitive and behavioral health screening, diagnoses, and history (including screening for Alzheimer's disease)²
- Community participation, employment, and volunteer status
- Consumer strengths, goals, values and priorities
- Demographic, contact, financial, and eligibility information
- Financial benefits and entitlements and financial and/or legal challenges
- Formal, informal, and social supports
- Functional assessment (activities of daily living [ADL], instrumental activities of daily living [IADL])
- Health-related services (including behavioral management, exercises, equipment use, skilled therapies, rehabilitation therapies) and all current providers
- Home and community environment, safety, accessibility, and health risks
- Long-term services and supports use and all current vendors
- Medical screening, diagnoses, and history
- Medication management practices
- Medications (including prescription, over-the-counter, herbal or naturopathic remedies and recently discontinued medicines)
- Nutrition (food access, preparation, diet, etc.)
- Preferred providers for acute care, post-acute care and pharmacy
- Self-care practices
- Social activities, roles, and important relationships to people, animals, places and possessions

The IDT should be alert for under-reporting of conditions due to incorrect beliefs that they represent normal aging, embarrassment, or fear of clinician response. These may include conditions such as depression, sleep disturbance, pain, incontinence, change in sexual function, memory loss, falls, constipation, excessive fatigue, driving mishaps, or risky use of alcohol, prescription or non-prescription drugs. IDT members should receive training in culturally appropriate methods to assess these conditions.

² Basic cognitive assessment tools include the Mini-Cog, Memory Impairment Screen (MIS), or GPCOG Screening Test. More information on cognitive assessment tools can be found here: <http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp#patientassesstools>

1.5 Individualized and Person-Centered Plan of Care

The IPC is the guiding document that identifies all the care, services, and supports for each consumer. It is a dynamic document, referenced, reviewed, and revised over time, depending on the needs and goals of the consumer.

1.5.1 Are the consumer's care goals, action steps to meet those goals, and proposed interventions to overcome identified challenges documented in the IPC?

IDT members need to be trained in working with and guiding consumers in identifying their personal goals – medical, social, or other (see 1.1.1 above).

1.5.2 Does the IPC contain specific documentation of what formal (paid) and informal (unpaid) care and supports are needed as well as care and support services are being provided?

Organizations with geriatric capacity ensure that accountability and timeframes are built into the IPC. Automated reminders are helpful in ensuring that IDT members regularly review and update the IPC. A checklist of such formal and informal services and supports may include: primary care, acute care, wellness care, behavioral health care, rehabilitation services, health education, transportation, personal care, housing with support pre-employment training, employment supports, social services, caregiver support, transitional care, assistive technology, money management, care management, and other care requested/specified by specialist physicians.

1.5.3 Do IDT members ensure that consumers understand and feel empowered to accept, negotiate, or modify changes made to their IPC?

Geriatric-competent organizations provide their staff with specific training and coaching to be sensitive to any consumer disagreement or resistance of care needs and goals specified in their IPC. Staff are trained to work with consumers to ensure concerns are addressed and consumers are aware of benefits and risks related to the IPC. For individuals with certain conditions (e.g., Alzheimer's disease), organizations may need to interact more closely with the consumer's family members or caregiver to address concerns or modify the IPC.

1.5.4 Do consumers and all members of the IDT have full access (electronically or on paper) to the initial IPC and any subsequent changes or updates?

Ideally the consumer's IPC is electronic and available to the consumer and all authorized providers (including those providing after-hours care). A paper version can serve as a substitute, especially if desired by the older consumer. The IPC should reside in a "central" location so the consumer and all authorized providers can reference it as needed. For paper versions of the IPC, copies should be made available to all members of the IDT.

1.6 Individualized and Person-Centered Plan of Care Oversight and Coordination

Ongoing oversight and review of the IPC is needed to ensure the plans are effective and being followed, that preventive strategies are in place, and that revisions are made based on the consumer's changing needs.

1.6.1 Are IDT members alerted when a consumer has a change in health status or care needs that affects the IPC?

Many geriatric-competent organizations use methods such as electronic triggers and signals to alert IDT members to needed or actual changes to the care plan. The types of changes that would be important for team members to know about are IPC review dates, changes in medications, routine reviews, hospitalizations, etc.

1.6.2 Is the IDT provided with clear criteria as to when a change in a consumer's health, condition, or caregiver status requires a revision to his or her IPC?

Criteria to trigger a review and possible revision to an IPC would include 1) consumer is receiving acute care such as a hospitalization, 2) consumer is in transition from one setting of care to another setting of care, 3) changes in consumer health or caregiver status, and 4) routine, prescheduled reviews. Unique elements such as death of the consumer's spouse might also be considered a trigger requiring review of the consumer's IPC.

1.6.3 Is the IDT provided with timely reminders to guide their work with each consumer as specified in the IPC?

Many organizations with geriatric capacity use methods such as electronic triggers to remind IDT members of outstanding items in a consumer's IPC that require attention.

1.7 Transitions

Transitions include changes between care settings, providers of care, and medications as well as financial, housing, legal, employment, and other changes that affect the older consumer's ability to live independently. It is during these transition times that misunderstandings, missed care and a variety of other errors occur may occur. Older adults have limited physiologic reserves and are at-risk of bad outcomes during poorly handled transitions. Those mishaps are more likely to be the cause of readmissions to acute care, set-backs in independence, and/or emotional or physical hardship. All transitions require vigilance by the IDT to identify and oversee the change to ensure the safety and well-being of the consumer.

1.7.1 Are there protocols to assist IDT members in managing key types of transitions?

Many organizations with geriatric expertise provide protocols that may be used for different types of transitions. Other organizations may employ a universal checklist of actions to be undertaken during different types of transitions. For example, following a discharge, a consumer should receive regularly scheduled follow-up from the provider to ensure that the discharge was successful. Transitions for consumers with cognitive impairments (e.g., Alzheimer's disease) may be particularly challenging, as this consumer population is often reliant on visual cues and other familiarities that may not be available in new settings.

1.7.2 Is a transition plan developed and implemented for all significant consumer changes?

Significant changes include all transitions that involve more than one area of the consumer's life. The IDT will want to ensure all care transitions are well documented and that all aspects of any transition, such as assistance with moving expenses or home modifications, are addressed.

1.7.3 Do all consumer transitions have an IDT member identified as responsible for ensuring successful completion and timely follow up?

For example, if the transition involves changes in medications, one IDT member may be responsible for providing medication reconciliation or coaching on signs and symptoms. This same individual would be responsible for bringing to the attention of the IDT that the consumer has a medication change. The IDT member would be alert for incomplete action items such as pending diagnostic tests or unscheduled medical appointments. Significant changes in health, function or caregiver support require not only revision of the IPC, but also education of the consumer and caregivers to assure they are confident about the new plan and have acquired new self-care skills, if necessary. The IDT confirms understanding through the use of "teach-back" and similar techniques. The transition plan includes at least one IDT member to be available to answer questions that emerge post-transition.

1.7.4 Are peer support and counseling services available to consumers considering or undertaking a transition process?

The IDT would want to make a list of resources available to the consumer for peer support and other counseling services, such as local Centers for Independent Living, Area Agencies on Aging, and Aging and Disability Resource Centers. The IDT may also add condition-specific resources to this list, such as Alzheimer's Association local chapters.

1.7.5 Does a significant change in the consumer's functional capacity trigger consideration of a potential transition plan?

Any significant change in a consumer's functional capacity, as demonstrated by a need to increase the type, amount or location of care, would necessitate the development of a transition plan. The transition plan may be a separate document, but would be included as a component of the IPC.

1.7.6 Does the IDT collaborate and provide resources to the caregiver or family member to assist with the transition?

Family members or caregivers may be essential partners to ensure a smooth and coordinated care transition. For certain consumer populations (e.g., individuals with Alzheimer's disease) or types of transitions (e.g., hospitalizations), IDT members may work with family members or caregivers to develop pre-planning checklists to prepare for the transition.³

³ Collaboration for Homecare Advances in Management and Practice (CHAMP): Advancing Home Care Excellence. Geriatric Care Transitions Toolkit: <http://www.champ-program.org/page/100/geriatric-care-transitions-toolkit>

1.8 Tailoring Services and Supports

Specific services and supports listed in the IPC should be derived from the assessments. They will also need to be modified as appropriate. The IPC specifies the individualized services and supports that are reflective of the consumer's preferences and needs to achieve his or her goals.

1.8.1 Are traditional services/supports substituted with alternative services that might not be considered "covered services" when appropriate?

Organizations with geriatric expertise consider all alternatives and assess the long-term benefit of providing the service/support, consumer preference, and cost-effectiveness. Examples include alternative transportation services, support groups, moving services, assistive technology loan programs, and complementary or alternative therapies (e.g., acupuncture, reiki, massage, curanderismo healing, etc.). Additionally, consumers are commonly the best source of creative, cost-effective alternatives. For example, consumers may identify a faith-based support group that can be rallied for a short period of time.

1.8.2 Does the IDT have the authority to modify the means of care delivery based on the unique context of the individual or a specific change in condition (either temporary or long-term)?

Organizations known for geriatric capacity empower the IDT to alter the scope, intensity, and frequency of care delivery, supports, and services when warranted. If managed care is involved, and authorization is required for resources, the criteria used for service authorization is made transparent to consumers and relevant providers.

1.9 Advance Care Planning

Completing and honoring advance care planning is an interactive process between the consumer and his or her IDT. The consumer's wishes help determine the course of his or her care and the identification of a proxy helps to ensure his or her wishes are honored in the event of the consumer's loss of capacity to make decisions. Geriatric-competent care requires IDT members being able to discuss end-of-life care issues with respect, sensitivity, and awareness. See Section 7.2 for a discussion of Advance Directives components (i.e., living wills, durable power of attorney for health care and mental health care). Other end-of-life care issues may include Do Not Resuscitate (DNR) orders, plans for palliative or hospice care, ventilator use, and artificial nutrition or hydration.

For consumers with cognitive impairment (e.g., Alzheimer's disease), loss of memory may impact their ability to participate meaningfully in decision making and makes early planning even more important. Although difficult questions often arise, advance planning can help people with Alzheimer's disease and their families clarify their wishes and make well-informed decisions about health care arrangements. When possible, the IDT may want to initiate advance care planning conversations soon after a diagnosis of early-stage Alzheimer's disease, while the consumer can still contribute and express clear and well-informed decisions.

1.9.1 Are consumers routinely asked to consider advance care planning?

Most organizations with geriatric capacity include a question or section regarding advance care planning, advance directives and other end-of-life care issues in the initial and recurring assessments.

1.9.2 Are staff trained in coaching consumers on advance care planning and end-of-life care decisions?

Many consumers expect health care providers to take the lead in discussions about health care decisions and advanced directives. Organizations with geriatric expertise will establish training for staff on how to effectively coach consumers on advance care planning and end-of-life care decisions, with sensitivity to diverse perspectives related to culture, disability, cognition and individual values and preferences.

1.9.3 Are consumers offered counseling or assistance in advance care planning?

Organizations should ensure consumers have competent guidance and assistance in completing advance care planning. Due to familiarity, trust, and openness, the consumer's primary contact on the IDT may provide this assistance to the consumer.

1.9.4 Are all advance care plans reviewed by the IDT and revisited at least annually with each consumer?

Triggers embedded in the IPC may serve as helpful reminders for the IDT to engage consumers in advance care planning discussions on an annual basis.

1.9.5 Are all completed advance care plans documented in the consumer's health record for access by all providers, including those providing after-hours care?

Signed copies of advance directives and other end-of-life documents should be sent to the consumer's primary care physician (if not a member of the IDT) and the consumer's preferred hospital, and should be entered into the EHR.

1.10 Allocation of Care Management and Services

Consumers need varying levels of care management support and assistance. The allocation methodology should be derived from the assessments and noted in the IPC.

1.10.1 Is there a process for determining the nature and amount of care management required by each consumer?

The following elements should be considered when assessing care management needs:

- Desire and ability to self-manage
- Functional dependencies
- Behavioral health issues
- Availability of home- and family-based supports
- Social and financial supports
- Frequency of inpatient and emergency department utilization
- Cognitive impairment and abilities
- Number of chronic conditions
- Risk for secondary complications of disability or chronic conditions, if applicable
- Complexity of IPC and stability of the formal/informal support team

1.10.2 Are consumer expectations and preferences a routine part of the assessment process for determining care management support provided by the IDT or other designated person?

It is important to specifically discuss the frequency and nature of care management to be provided as part of the assessment process so that the consumer's expectations are identified, discussed, and met.

1.10.3 Does the IDT review and discuss the consumer's expectations of care management during all reassessments to ensure he or she receives the level, nature, and timeliness of care management he or she desires and requires?

Encourage each consumer to communicate about the needed care, supports, and services he or she feels are lacking and encourage the consumer to give feedback to the IDT on whether or not expectations are met.

1.10.4 Are consumers specifically coached as to when and how they may seek and obtain care management support?

Geriatric-competent organizations encourage consumers to call their primary care practitioner, care manager, or IDT lead upon first indication of illness so that plans can be implemented to ensure the appropriate level of care.

1.11 Interacting with Care Partners

Care partners (usually unpaid) are spouses, friends, or relatives who provide assistance to the consumer. Another term for these valuable resources is “natural supports” or “informal” support. The key criterion is that these individuals provide valuable help without being monetarily compensated. An example is the daughter who helps the consumer dress and bathe, or neighbors who helps the consumer with grocery shopping because they are willing and able to do this for the consumer. Refer to **Domain 5 - Caregiving** for more information on informal support.

1.11.1 Does the IDT routinely inquire whether consumers have an ongoing care partner who accompanies the consumer to medical appointments, and does the IDT recommend this process when necessary?

A care partner can provide assistance to the consumer who has complex care needs or cognitive limitations, such as accompanying the consumer to medical appointments. The care partner can coach the consumer to ask questions during the appointment, assist with adherence to the care plan, and provide support while the consumer is accessing care. In the case of consumers previously diagnosed with Alzheimer’s disease, the presence of a legal guardian or care partner may be necessary to ensure that the consumer’s choices are respected and incorporated into the care plan. IDTs can have a process in place to recommend that a legal guardian or care partner is present during medical appointments, when necessary.

1.11.2 Is there a means of communication established between the IDT and the identified care partner?

The presence of a care partner ought to be noted in the consumer’s IPC with documentation regarding the nature and means for communication between the IDT and care partner. It is important to understand the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule when sharing information with the consumer’s care partners.⁴

1.11.3 Are care partners offered training to prepare them for their support role?

This training is usually informal, though it may include specific evidence-based education regarding preventive strategies and identification of warning signs, such as “Savvy Caregiver.”⁵ Additionally, training may include condition-specific content, such as training to care for consumers with Alzheimer’s disease.⁶ It is also important to evaluate the care partner’s ability and interest in serving in this role.

⁴ The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is the first comprehensive Federal protection for the privacy of personal health information. http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/HIPAAGenInfo/06_AreYouCoveredEntity.asp

⁵ US DHHS Administration for Community Living, Administration on Aging: An Evidence-Based Intervention for Alzheimer’s and Dementia Care. http://www.aoa.acl.gov/AoA_Programs/HPW/Alz_Grants/caregiver.aspx

⁶ Online resources such as the National Institute on Aging and the Alzheimer’s Association, offer many tips and guidelines: <http://www.alz.org/care/alzheimers-dementia-care-training-certification.asp>

1.12 Health Record

A comprehensive health record is composed of many elements, including assessment(s), the IPC, medication lists, referrals and authorizations, care management notes, and other information as appropriate. The IDT overseeing the overall plan of care is responsible for having and maintaining a comprehensive health record for each consumer. Having an electronic health record (EHR) for each consumer aids communication and coordination but the IDT will want to be cognizant that not all involved in a particular consumer's care will have the capability of accessing or be able to generate electronic records.

1.12.1 Is all information (e.g., medical, social, medications, financial) for each consumer documented, maintained, and updated within the health record for that?

The consumer's health record is ideally available via electronic means. If this is not possible, the health record should be available to the consumer and all providers via paper, fax, or email.

1.12.2 If an EHR is maintained, is it interoperable with EHRs of key providers involved in the consumer's care?

At a minimum, a paper or electronic document is shared with all providers involved in the consumer's care. The ideal is to have an EHR that is able to incorporate the medical records, care management activities, and service plans from all providers and settings engaged in the consumer's care.

1.12.3 Does an IDT member or support person specifically manage, update, and disseminate each consumer's information to appropriate providers as discussed with and approved by the consumer?

This person is typically a clinical office-based team assistant or support person available during working hours to facilitate communications. In non-clinical settings or with non-primary care entities, agreements may be in place with accountable care or managed care organizations to provide full or partial access to EHR information.

1.12.4 Is there a means to quickly access, communicate, and disseminate key consumer information, especially for anyone providing after-hours coverage?

Geriatric-competent organizations commonly provide key information in a readily accessible location (e.g. a virtual "front page" or summary screens) of the consumer's EHR. If there is no EHR, the IDT will have protocols and a means to provide key information. Consumers with Alzheimer's disease may require real-time tracking programs, such as Silver Alert or MedicAlert, to help prevent and mitigate the risk of wandering.

1.12.5 Is utilization data in the health record routinely reviewed by the IDT to identify areas for clinical intervention and quality improvement?

It is very helpful to have real-time administrative data for emergency department visits and inpatient hospital admissions (including diagnostic information) to identify potentially preventable admissions or conditions that are amenable to health education and enhanced consumer support. Additionally, real-time pharmaceutical data is useful to identify a change in condition, track adherence, and enhance comprehensive medication management, including but not limited to medication reconciliation.

1.12.6 Is pertinent clinical and utilization data routinely provided to external providers to identify opportunities for improvement?

Data on consumer costs, emergency department visits, specialty referrals, behavioral health services, pharmaceutical services, inpatient hospital admissions, LTSS utilization, care management contacts and risk indicators (e.g., falls, high alert medicines) can be used to create management reports that serve as a source of feedback and as opportunities to coach providers. Reports reflecting the experience of a provider's full panel of consumers provide an opportunity to identify promising practices and areas for improvement. Predictive modeling may identify key variables associated with health care and LTSS utilization that enable providers to tailor services and intervene to optimize clinical and financial outcomes.

1.12.7 Does the consumer have the ability to access all components of his or her health record?

At a minimum, the consumer should be able to review all components of his or her health record during visits with his or her primary care practitioner.

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.⁷ 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
- Psychiatry
- Cardiology
- Pulmonology
- Endocrinology
- Urology
- Gastroenterology
- Pain Management
- Behavioral Health
- Oncology
- Hearing/audiology

⁷ 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.⁸

⁸ 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 remotely⁹
- Medi-Alert
- Foreign language translation
- American Sign Language (ASL) and ASL interpreters
- Teletypewriter (TTY)¹⁰ 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.¹¹

⁹ Telemedicine is the exchange of medical information from one electronic site to another, in the interest of improving a consumer's clinical health status.

¹⁰ 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.

¹¹ 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).

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 her 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](https://www.medicaid.gov).¹²

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.

¹² 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 services¹³
- 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.

¹³ 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.

4 ALTERNATE LIVING ARRANGEMENTS

It is important to understand the setting within which the older person lives. These possible or already existing arrangements should be discussed with all who are involved in ensuring safety, quality of life, and the least restrictive setting of care. Practitioners and other providers will want to be familiar with various living arrangements so they understand the limitations and the strengths of the setting of care within which the consumer already resides. Geriatric consumers, their family and/or their caregivers, health care providers, and others involved in their lives such as a home- and community-based provider may identify the possible need for the consumer to reside somewhere other than their own home to ensure safety and quality of life. There are a wide variety of options available to consumers seeking an alternative arrangement and the practitioner will want to be knowledgeable of the similarities and differences between the many options. Autonomy and choice is at the core of consumer-centered care and relationships. It is important to offer as wide a choice of facilities as possible and to consider geographic locations in order to facilitate existing relationships with family and friends. With the approval of participants, direct care workers and/or their supervisors can be involved in the assessment and care planning process with the IDT if not already directly involved. Included in this assessment are six major types of living arrangements within which an older person may reside: congregate housing facilities, assisted living and residential living facilities, board and care homes, residential treatment centers (behavioral health focus), State Veterans Homes, and residential nursing homes. Consumers may also choose to live with family or friends, or alone.

4.1 Congregate Housing Facilities

Congregate housing facilities provide seniors with private accommodations and some shared living spaces. Most facilities will provide at least one daily meal, social activities, and housekeeping and may provide limited assistance with activities of daily living. They do not provide 24-hour supervision or health care services, but may contract out for some assistance services. Congregate housing facilities are not licensed and are not staffed by health care professionals. These residences are well suited for individuals who are self-sufficient, require only minor assistance with basic tasks, and would enjoy the company of other residents. Seniors who need daily assistance and/or extensive services should explore other resources for more extensive in-home support. Some congregate facilities may be subsidized by state governments, via Medicaid.

4.1.1 Is staff able to offer information and resources about congregate housing facilities or refer the consumer to someone who can assist him/her with this option for living?

Organizations or practices will want to have enough knowledge about congregate housing facilities so they can suggest this option to the consumer and connect the consumer with someone who can assist the individual to explore this option for living.

4.1.2 Does staff know the functional capability a person must have to reside in this setting of care?

Organizations or practices will want to have enough knowledge about congregate housing facilities in order to understand if this is a safe solution to the older consumer's need.

4.2 Assisted Living Facilities and Residential Facilities

Assisted living facilities and residential facilities generally provide housing and supportive services for six or more residents. Both types of facilities are well suited for consumers who only need assistance with a small number of tasks, such as cooking, laundry, and taking medications. There are some structural differences for residents as indicated in the table below.

	Assisted Living Facilities	Residential Facilities
Room Accommodations	Private, independent apartments ranging from a studio to one or two bedrooms. Wheelchair accessible.	Shared accommodations with shared bathrooms or common bathrooms. No private kitchenettes.

In most states, neither facility is required to have licensed registered nurses on staff 24-hours-a-day. Duties and qualifications of direct caregivers will vary among facilities. Staff to resident ratio will typically be lower than what is required for nursing homes. Residents may also have home health nursing services (including visits by licensed nurses, physical therapists, occupational therapists and nurse aids) for a short-term skilled medical need or through private payment means to augment the limited assistance they receive in the assisted living facility. Residents typically pay monthly rent as well as additional fees for the services they require. In some states, publicly supported assisted living options may be available. Geriatric providers will want to maintain familiarity of and communication with assisted living facilities in the region.

4.2.1 Can you offer information and resources about assisted living facilities and residential facilities?

Practitioners and the IDT need not be experts on the financial requirements and functional criteria necessary to reside in these settings of care, but should be aware of the general parameters of care provided. In doing so, further assessment of whether the setting is appropriate, safe and adequately meeting the needs of the consumer for activities of daily living is possible. Assisted living and residential facilities vary in the degree of support for person-centered living and consumers should be encouraged to visit, meet the care team, and ask questions about consumer choice, autonomy, activities and involvement in the residential community. Facilities also vary in the preparation and training of direct care workers in supporting persons with dementia, including Alzheimer's. Geriatric providers know approximate costs for facilities in the consumer's locale or who to contact to facilitate assessment of the consumer for this level of care and to assist with transition if needed. Local aging networks and agencies serving the geriatric population are the best source for further information on board and care facilities.

4.2.2 Do you know the functional capability a person must have to reside in this setting of care?

It is important to have a general knowledge of the support assisted living facilities and residential facilities can reasonably be expected to provide to the older adult. Knowing the capabilities of the consumer facilitates assessment of whether the setting of care is appropriate and, as changes occur in the older person's abilities, that the arrangement still ensures safety and well-being. It also assists the practitioner and family/caregiver to understand what can or cannot be accomplished within this setting of care (e.g., does the facility remind a consumer of the need to take a medication) or social dynamics that may impact the consumer's well-being (e.g., a room-mate is wandering around and interrupting the consumer's sleep).

4.3 Board and Care Homes and Adult Foster Homes

A board and care home is a group living arrangement that meets the needs of individuals who do not require nursing home services but also cannot live as independently as someone in an assisted living or residential facility setting. Care is usually offered within private residences to not more than 5-6 persons at a time. The homes typically offer assistance with daily, routine activities such as providing meals, doing laundry, and providing transportation and socialization. In some states, adult foster homes or adult family care is a more structured service that may include assistance with personal care (such as eating, bathing or dressing) and training and supervision for direct care providers. Private long term care insurance and medical assistance programs may help pay for this alternate living arrangement. People often choose this setting of care because it is more affordable than other facilities and it is more of a homelike setting.

4.3.1 Can you offer information and resources about board and care homes and adult foster homes?

Geriatric providers will want to be aware of board and care options and adult foster home options in the region and be able to assist members with finding more information. Local aging networks and agencies serving the geriatric population are the best source for further information on board and care facilities.

4.3.2 Do you know the functional capability a person must have to reside in this setting of care?

Board and care homes and adult foster homes generally provide a significantly lower level of care than a traditional nursing home and would be best suited for individuals that only need assistance with daily living activities. Regulation and monitoring of these facilities varies significantly by state and, therefore, the level of care that each facility provides may also vary. A provider can assist in matching a particular facility to an individual's functional capacity, financial resources, and geographical preferences (e.g., one that is located closer to a relative that can visit frequently).

4.4 Residential Treatment Centers

Residential treatment centers are facilities for individuals suffering from mental illness, including substance abuse. Also known as rehabilitation programs, these facilities provide a slower paced, more repetitive treatment plan for residents and, if targeted for geriatric consumers, will also demonstrate competency in aging issues. These centers will vary in the types of conditions that they treat. For example, centers specializing in the treatment of substance abuse will typically offer a shorter term treatment plan than those specializing in the treatment of behavioral disorders. Residential treatment centers may also specialize in serving a particular population (e.g., women, children, seniors). The most common services provided by these facilities include assistance and training with daily living activities, medication management, client advocacy and case management, and individual counseling.

4.4.1 Can you offer information and resources about residential treatment centers?

Providers serving geriatric consumers are able to identify residential treatment centers in the state that specialize in serving older adults with behavioral concerns, mental illness and substance abuse. They will want to be able to discuss different levels of treatment offered by the facilities. A familiarity with state regulations is also prudent; each state regulates these facilities differently and assigns a state-specific designation based on the level of care offered. It is prudent that any discussion of residential treatment involve communication with a behavioral health practitioner¹⁴.

4.4.2 Do you know the functional capability a person must have to reside in this setting of care?

Residential treatment centers offer high intensity services in a specialized care setting and are designed for individuals with low functional and mental capability. Consumers in these facilities are cognitively impaired because of mental illness and/or substance abuse and typically lack the social network and resources needed to manage their illness. A key issue for practitioners and other providers is to discern if a residential treatment center also is knowledgeable and sensitive to aging issues. Consumers with higher functional capability may be able to receive rehabilitation services in an alternate care setting, such as a State Veterans Home, a board and care home or a halfway house. Consumers at higher risk may need constant one-on-one monitoring in a 24-hour psychiatric intensive treatment setting.

¹⁴ 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.

4.5 State Veterans Homes

State Veterans Homes provide skilled nursing homes, domiciliary care (or residential nursing homes), and adult day care, in facilities that are owned and operated by state governments. Eligibility depends on clinical need, setting availability, and other criteria that are specific to each state, and Veteran status. Some facilities may admit spouses and gold star parents¹⁵. The Department of Veterans Affairs does not manage these facilities, but does certify and survey the facilities annually before they receive funding from state governments.

4.5.1 Can you offer information and resources about State Veterans Homes?

A Veteran Affairs (VA) social worker is the best resource for further information and for assistance in determining the needs of a specific consumer. VA social workers can identify the nearest State Veterans Homes and can help consumers determine a plan for paying for the services. A VA social worker can be contacted at any VA medical center. A list of State Veterans Homes can also be found on the website for the National Association of State Veterans Homes.

4.5.2 Do you know the functional capability a person must have to reside in this setting of care?

State Veterans Homes vary in the types of services that they offer. If the services provided do not meet the needs of a consumer, then the consumer may need assistance from a caregiver in addition to the State Veterans Home. Determination of functional capability involves open communication among the consumer, the provider, the VA social worker and relatives.

¹⁵ A gold star parent is a mother or father of a service member who lost their life in service to the country.

4.6 Residential Nursing Homes

Residential nursing homes (sometimes referred to as custodial) and hereafter in this document referred to as nursing homes, offer a permanent residence for members who are of limited functional ability to care for themselves at home. Skilled nursing homes or facilities (SNF) should not be confused with a nursing home; however, the latter may be a wing or section of designated rooms within a skilled nursing facility. In a skilled nursing facility, a consumer generally stays for a short term (e.g., approximately 2-3 weeks) after an acute care hospitalization because he or she needs additional “skilled medical” care or rehabilitation services. This type of skilled nursing care stay is covered by Medicare. Residential nursing homes, in contrast, are intended to provide a more intensive level of residential, health, nursing and personal care support than can be provided in the community. The residential nursing home offers a wide array of services and is generally staffed by nursing assistants supervised by licensed vocational nurses and/or registered nurses with a medical director who is available as needed. The costs of residential nursing homes are typically subsidized by Medicaid if a consumer meets long term care (LTC) eligibility requirements. Residents may have some share of costs for the room and board aspect of the care. State agencies conduct routine inspections of nursing homes, and these reports are available online.

4.6.1 Can you offer information and resources about Residential Nursing Homes?

Given the high volume of nursing homes in the United States and use of this option to provide care for the older generation, providers will want to be able to guide members in comparing different nursing homes and determining one that will best meet the consumer’s needs. The Centers for Medicaid and Medicare Services maintains a robust database of residential nursing homes in the United States and allows consumers to compare services offered by various facilities: <http://www.medicare.gov/nursinghomecompare/search.html>. The Center also provides a checklist guide for assessing a nursing home: <http://www.medicare.gov/NursingHomeCompare/checklist.pdf>. Nursing homes vary in the degree of person centeredness and consumers should be encouraged to visit, meet the care team and ask questions about consumer choice, autonomy, activities and involvement in the residential community. Facilities also vary in the preparation and training of direct care workers in supporting persons with dementia, including Alzheimer’s. States are interested in and supporting waivers in LTC eligibility requirements to facilitate older individuals to return to community settings of care. Practitioners and providers working with care managers can identify, assess, and support this option of living in the least restrictive setting of care. Consumer involvement in decision-making and preparation for transition to a residential nursing home is important to post-relocation adaptation and well-being. Geriatric providers are aware of evidence-based guidelines to facilitate consumer well-being during the relocation process.

4.6.2 Do you know the functional capability a person must have to reside in this setting of care?

A consumer must complete a state-specific functional assessment to qualify for Medicaid reimbursement for residential nursing home services. Consumers must meet functional limitations and disability criteria that differ by state. Geriatric providers are knowledgeable of the criteria that apply to their region and be able to discuss whether or not a consumer may be eligible.

4.7 Living with a family member or friend

Living with a family member or a friend is an option for older individuals who have a higher functional capability and a caregiver willing to assist them. Programs such as Meals on Wheels, shopping services, and adult day care are available in most communities and can complement assistance provided by a caregiver. Consumers can also arrange for aids to visit the home on a routine basis to assist with, for example, bathing. Some agencies will provide respite care for a few days if consumers need short-term care while the caregiver takes a break or is called away on an emergency. Funding for these in-home services may come from Area Agencies on Aging or various state-funded programs. Your state's Medicaid agency may offer waivers that provide partial or full reimbursement services received in the home rather than in institutional settings.

4.7.1 Can you offer information and resources about residential nursing homes?

Providers serving geriatric consumers are typically familiar with the various services that can reach consumers at home and can complement assistance from friends and relatives. A referral coordinator can maintain a database of in-home services providers in the region, as well as the state's waivers and available programs. Any discussion of living at home should involve open communication with all caregivers, friends and relatives.

4.7.2 Do you know the functional capability a person must have to reside in this setting of care?

The functional capability of a consumer living with a friend or relative can vary widely based on the assistance that the caregiver is able to provide (commonly referred to as natural support) and the in-home services that the consumer is able to afford. A consumer's ability to live at home will also depend on the home's accessibility. Depending on a consumer's functional capability and on Medicaid waivers available in your state, a consumer may qualify for reimbursement for certain in-home services that help them with their ADLs.

5 CAREGIVING

There is no single definition of caregiving used across organizations, government entities, and the health care industry. Generally, a caregiver is an individual who is responsible for attending to the daily needs of another person unable to manage independently for him or herself.

There is a distinction between paid caregivers, which include home and community based workers who are trained and compensated for their services (see **Domain 3 - Long Term Services and Supports**), and individuals and resources a consumer can access through personal associations and relationships typically developed in the community, independent of formal services. These resources are usually sustainable and available to the consumer after formal services have ended. They may include relationships with family members, partners, friends, neighbors, community and civic organizations, or others who provide assistance to the consumer. Individuals who provide this care are often referred to as “informal caregivers” or “natural supports” and are usually not paid.

Caregivers provide physical, emotional, and often financial support to the individual requiring assistance due to illness, injury, disability or frailness. Informal caregiving is vital to consumers remaining in the least restrictive setting. The geriatric population often has an increased need for assistance related to chronic conditions or functional decline. A reality that is not often considered is that an older person may provide caregiving services to his or her spouse, sibling, friend (who also may be an older person), adult child, or grandchild without much, if any, external support. Providers interacting with older individuals will want to understand the natural supports the person has or can mobilize and the caregiving responsibilities the consumer has for others.

5.1 Older Adults as Recipients of Informal Care

The elderly are often in need of caregiving services from relatives, partners, friends, and community members. These “unpaid” services are vital for the geriatric consumer to live in the least restrictive setting possible. People supporting the older adult in this way are valuable sources of information and assistance to providers. Caregiving for consumers with certain conditions (e.g., Alzheimer’s disease) may require more intensive support and involvement in the consumer’s life.

5.1.1 Is the IDT aware of what needs are being met through the natural supports of the geriatric consumer and by whom, and what services are provided through more formal provisions of care by hired workers?

Elderly consumers may need informal caregiving for a short-term, long-term, or indefinite period of time. These natural supports cover a wide range of activities and goods including, but not limited to:

- Assistance with activities of daily living, including walking, bathing, dressing, eating, and toileting
- Assistance with instrumental activities of daily living, including shopping, food preparation, housekeeping, laundry, and using the telephone or computer
- Assistance with monitoring symptoms and administering medication
- Emotional and social support
- Finding and accessing services, including housing and medical supports
- Behavioral support, including communicating effectively and recognizing and responding to behavioral expressions in persons living with dementia (e.g., wandering, aggression, and hallucinations)
- Financial assistance, including managing bills and/or direct financial support

5.1.2 Are informal caregivers noted as part of the medical record?

Recognizing the importance of natural supports for the geriatric consumer, organizations with geriatric capacity will enhance care coordination by including the consumer’s informal caregiver(s) in their records as resources of information and support to the older person. It is also important that this information is routinely verified and updated. Caregivers who are not local may also need to be included in the decision-making process and should be included as appropriate.

5.1.3 Are informal caregivers a part of the consumer’s IPC?

Relatives, partners, and friends serving as informal caregivers are often the best resource for information on the consumer’s day-to-day physical and mental status. Organizations with geriatric capacity involve informal caregivers in the IPC, with the geriatric consumer’s permission, in order to fully ascertain the consumer’s functional, mental, and emotional capacities and needs. Consumers may also designate informal caregivers to be involved in IDT-

related communications and assessments – see 1.3.1.7 and 1.4.4 (**Domain 1 – Relational-based Care Management**) for more information.

5.1.4 Do IDT staff regularly consult consumers about their options to share protected health care information with caregivers?

Organizations with high levels of geriatric capacity and expertise with caregiver involvement regularly consult consumers about sharing health information with family and non-family caregivers. IDT staff must understand their role in protecting the consumer’s Protected Health Information (PHI) under Title II of the Health Insurance Portability and Accountability Act as well as the necessary steps to facilitate sharing PHI with the consumer’s appointed caregiver or caregivers should the consumer choose to do so. See question 7.2.4 for more information on the role of HIPAA in an organization with geriatric capacity.

5.1.5 Are IDT staff trained to watch for, and report, problematic caregiver relationships, such as abuse, neglect, and exploitation?

In addition to identifying potentially problematic interactions and relationships, staff will want to be knowledgeable and comfortable to respectfully address concerns with the consumer and others as appropriate. Organizations with geriatric expertise have reporting guidelines for staff to follow in the case of a problematic caregiver relationship.

5.1.6 Are staff aware of an older consumer’s back-up plan to provide replacement caregiving in case of an emergency and resources that staff may contact to assist the consumer if needed?

When an informal caregiver is unexpectedly unable to provide help, the consumer’s physical and mental health may be at risk. Organizations with geriatric capacity maintain listings of resources available to consumers during such emergency periods. Substitute caregiving services are necessary to ensure that a consumer is not placed in a more restrictive care setting due to a temporary lapse in informal caregiving services.

5.1.7 Are staff aware of respite care available for consumers’ informal caregivers?

Respite care is the planned provision of a short period of rest or relief for informal caregivers who routinely provide caregiving services to an individual. It may help the caregiver avoid burnout and therefore continue providing services for a longer period of time, allowing the consumer to remain in a less restrictive care setting. Respite care may be provided by paid home health aides or personal care assistants in the home, or the care recipient may temporarily receive care in a setting outside the original residence. Some examples of respite care include¹⁶:

¹⁶ Alzheimer’s Association: Respite Care: <https://www.alz.org/care/alzheimers-dementia-caregiver-respite.asp>

- In-home care services: this can include a range of services offering companionship to the consumer, assistance with bathing, dressing, toileting and exercising, homemaker or maid services, and skilled care services to help with medication and other medical services.
- Adult day centers: these are designed to be a safe and social environment for the consumer with activities led by trained staff. Transportation and meals are often provided.
- Residential facilities: these facilities offer short-term, overnight accommodations for the consumer that can allow for the caregiver to take an extended break or vacation.

Additional sections in this Tool related to informal caregiving that may be useful to review include the following:

- Domain 1 – Relational-based Care Management
 - 1.1.3 – Involving older consumers, families, and caregivers, in care planning and implementation to ensure a consumer-centered focus
 - 1.7.6 – IDT collaborating and providing resources to the caregiver or family member to assist with care transitions
 - 1.11 – Interacting with caregivers
- Domain 2 – Highly Responsive Primary Care
 - 2.3.4 – Consumer and caregiver training in medication administration
- Domain 4 – Alternate Living Arrangements
 - 4.7 – Living with a family member or friend

5.2 Older Adults as Providers of Informal Care

Older adults are not only on the receiving end of caregiving. Increasingly, older adults provide informal caregiving services to their elderly spouse/partner, relatives, and friends. Longer lives and changes in family demographics such as grown children living distances from their elderly parents and/or working hours that make offspring less available to assist older parents, requires older people to look for non-family alternatives for assistance. Spouses or life-long partners often compensate for each other's functional limitations. In other situations, an older person may be providing caregiving to children or a disabled person(s). These types of caregiving relationships may greatly impact all involved, including the geriatric consumer.

5.2.1 Are IDT staff aware of consumers' roles as caregivers to an elderly partner, family member, friend, or neighbor?

Organizations with geriatric capacity ensure that their staff identify the caregiving services that older adults provide to partners, relatives, and friends. Routine assessment of caregiving roles allows the IDT a holistic picture of the consumer's physical, emotional, and social well-being.

5.2.2 Are IDT staff trained to assess the effect of caregiving on the geriatric consumer's physical, emotional, and financial status?

Caregiving often requires an enormous physical and emotional commitment to the care recipient. An older caregiver faces additional burdens due to poor health, functional or mental decline or disability. Organizations with geriatric capacity may use formal assessment tools and train their staff to recognize potential harmful effects of being a caregiver, including:

- Chronic stress, frustration, loss of self-identity, lower levels of self-esteem, constant worry or feelings of uncertainty
- Depression
- Physical and mental exhaustion
- Increased alcohol, tobacco, or substance use
- Hostility and threats of harmful behavior toward the care recipient
- Increased health problems and functional limitations that make caring for others more difficult
- Decreased self-care, including less frequent preventative health behaviors, missed doctors' appointments and prescription refills, poorer diet and exercise habits

5.2.3 Are the consumer's caregiving responsibilities noted as part of the consumer's IPC?

Organizations with geriatric expertise recognize the effect being a caregiver has on the consumer's physical and mental health. The IPC takes into consideration the limitations that this responsibility places on the consumer's ability to attain IPC goals.

5.2.4 Are IDT staff aware of resources, including respite care, for the elderly caregiver?

Organizations with geriatric expertise ensure that consumers who provide caregiving to partners, relatives, and friends have access to respite care and other resources as explained in 5.1.6. IDT staff should be prepared to offer Alzheimer’s-specific resources to caregivers, such as the National Institute on Aging’s guide to “Caring for a Person with Alzheimer’s Disease,” national advocacy groups such as the Family Caregiver Alliance or Dementia Action Alliance, and local supports available in their communities.¹⁷

¹⁷ National Institute on Aging: “Caring for a Person with Alzheimer’s Disease”
<https://www.nia.nih.gov/alzheimers/publication/caring-person-alzheimers-disease/about-guide>

5.3 Older Adults as Caregivers to Children

Over the past decade, elderly consumers have increasingly assumed the role of caregivers for their grandchildren.¹⁸ This type of responsibility may also extend to other minors such as nieces or nephews. Regardless of the relationship, we refer to the older consumer in this role as a grandparent caregiver. There are many practical issues involved in caring for a child, including legal and financial issues. There are also health considerations for the older consumer who provides caregiving services and supports to children under the age of 18.

5.3.1 Are IDT staff aware of their geriatric consumers who have custody of children?

Organizations with geriatric expertise stay abreast of the consumer's caregiving responsibilities, specifically when the consumer is raising one or more children under the age of 18.

5.3.2 Are IDT staff aware of the effects on the consumer's physical, emotional, and financial well-being of raising a child or children?

In addition to challenges faced by all caregivers noted in 5.2.2 above, grandparent caregivers may have the added burden of:

- raising children on a fixed income
- finding or maintaining adequate housing
- experiencing their own health problems and functional limitations that make caring for children more difficult
- raising children who may have behavioral and emotional problems due to various factors, including an unstable home environment or history of parental drug use and neglect

5.3.3 Are IDT staff aware of resources available to grandparent caregivers?

Geriatric-competent organizations have general knowledge of community, financial, and legal resources available to older consumers still raising children. Staff know how to connect the older person with the right resource or a point person to assist them with their needs. Community resources may include respite care, low-cost day care, and school programs.

Financial resources may include a case manager or social worker who is informed on Medicaid, Children's Health Insurance Program (CHIP), and Temporary Assistance to Needy Families (TANF) eligibility for grandchildren under the care of an older adult. If the grandchild is mentally or physically disabled, Supplemental Security Income may pay cash benefits. Legal resources include information and support for grandparents in the following areas:

- Physical custody
- Legal custody
- Guardianship
- Adoption

¹⁸ Livingston, G., & Parker, K. (2010) Since the Start of the Great Recession, More Children Raised by Grandparents. Pew Research: Social & Demographic Trends. September 9, 2010. Retrieved from: <http://www.pewsocialtrends.org/2010/09/09/since-the-start-of-the-great-recession-more-children-raised-by-grandparents/>

6 BENEFITS AND RESOURCES

Having both Medicare and Medicaid does not always meet all the needs of the older individual because of the different categories or levels of coverage for which a person is eligible. Medicare covers different types of services and goods depending on the plan(s) for which the person is eligible or elects – Part A, B, C, D, and a Hospice benefit. A person with Medicare coverage may have Part A (acute care) and D (medications) but not Part B (supplementary which covers outpatient care and durable medical equipment) or Part C (managed care). Medicare does not cover long term support and services in the community so Medicaid programs provide these services when the individual is eligible through his or her Medicaid program. Medicaid benefit determination identifies whether an individual is eligible for “full” Medicaid or “partial” Medicaid benefits. Each state determines for their constituents what services Medicaid will cover and how much of the Medicare co-payment will be financed by the state. The dual status of having both Medicare and Medicaid is an amalgamation of each program of health and LTSS insurance rather than separate benefit coverage. Consumers that are entitled to benefits under Medicare as well as Medicaid are referred to as “Medicare-Medicaid enrollees”.

Added to the complexity of coverage between Medicare and Medicaid is the bifurcation of reimbursement sources for providers. Although a person has dual coverage, payment for services and goods comes from the two separate coffers – federal and state. Additionally, each system manages and coordinates what services and goods are authorized independently of each other. Recent innovations and demonstrations are striving to correct inefficiencies and resolve any confusion by better synergizing or articulating these funding streams into a seamless system. Specific CMS departments have been created to coordinate financial alignment initiatives and coordinate communication. In addition, demonstration models of care, such as the Financial Alignment Initiative, have been instituted in which states, managed care plans and the Medicare system cooperate to coordinate care

for Medicare-Medicaid individuals and funnel Medicare and Medicaid reimbursement through one stream to be managed by the state.¹⁹

Practitioners and other providers will want to understand, at least at a high level, just how complex these issues are for the geriatric Medicare-Medicaid consumer and his or her family. Providers will want to know to whom and where to refer older consumers for assistance with understanding their benefits and obtaining needed services or goods, both covered and not covered by their insurance. They may also need to provide clinical consultation or written justification to assist an older Medicare-Medicaid enrollee to become eligible for needed services.

¹⁹ CMS Innovation Center <http://innovation.cms.gov/>

6.1 Insurance Coverage

Geriatric consumers may have Medicare coverage, Medicaid coverage, both, and may also have private insurance. Within Medicare, there are several coverage types – Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage) and Part D (outpatient pharmacy). Not all beneficiaries have all types. Some individuals elect to receive all benefits through managed care under Medicare Advantage.

Some Medicare beneficiaries may also be eligible for Medicaid benefits based on limited income and resources or disability. Depending on the state in which the person resides and whether he or she has full or partial benefit eligibility, Medicaid may provide assistance with paying for Medicare premiums and additional out-of-pocket medical expenses. These individuals may also be eligible for other services not provided under Medicare such as long term support services.

Some consumers may also purchase Medicare Supplement Insurance (Medigap) policy, retiree insurance, or other private plans. Some consumers also have Veterans benefits.

6.1.1 Does the IDT understand what is meant by dual eligible coverage and the demographics of this population, and in particular the older consumer within this distinct group?

Medicare-Medicaid enrollees as a group are among the sickest and poorest individuals in the country. Over half of Medicare-Medicaid Enrollees are low-income geriatric consumers. These individuals rely on their providers to help them navigate complex insurance programs and health and service systems to obtain services and coverage that they are entitled to as a Medicare-Medicaid consumer.

6.1.2 Is staff knowledgeable generally of the different types of Medicare eligibility and the various eligibility categories for Medicaid?

Providers and involved individuals in an older consumer's care can enhance care coordination activities with a foundational knowledge of Medicare and Medicaid eligibility requirements. In addition to the parts of Medicare coverage, there are Medicare categories designed for specific occupation such as Railroaders Medicare and Black Lung Medicare. Individuals with full Medicaid coverage and those with partial Medicaid benefits are further categorized within each of those classifications, affecting what services and benefits are covered.²⁰ Providers need not be experts in this knowledge base but rather have enough understanding to facilitate care and direct the older consumer to expert advice and .

²⁰ Centers for Medicare and Medicaid Services. Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance. Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf

6.1.3 Is staff knowledgeable of whom and where to refer Medicare-Medicaid enrollees for explanations and understanding of their Medicare coverage as well as their Medicaid policy?

Providers and others involved in the individual's care will want to provide information to each consumer about the resources that can help him or her obtain needed information about Medicaid, Medicare and community resources. Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging, and State Health Insurance Assistance Programs (SHIP), as well as Certified Professional Geriatric Care Managers and Geriatric Social Workers are experts in identifying these resources.

6.1.4 Is staff knowledgeable at a general level about how supplemental insurance options help provide coverage for older consumers?

Consumers who are enrolled in Medicare Part A and Part B may also choose to enroll in Medicare supplemental insurance, also known as Medigap. Medigap policies are sold by private companies and help to pay some health care costs that Medicare does not cover. This type of service may be especially beneficial for Medicare-Medicaid enrollees who receive limited or no state Medicaid funding for particular goods or services because of the category of Medicaid eligibility they hold or the state's particular coverage limitations.

6.2 Benefits, Services, and Programs Available to Medicare-Medicaid Beneficiaries

Medicare-Medicaid enrollees are entitled to programs and services available under both Medicare and Medicaid. Benefits under Medicaid vary greatly by state because of the authority and funding state governments apply to their Medicaid programs. State Medicaid agencies can also apply to CMS for waivers that allow them to use federal funding to contribute to their management of Medicaid programs in order to enhance the services that are available to specific populations.

6.2.1 Is staff generally knowledgeable about Medicaid benefits, regardless of what state administers the program?

Medicare-Medicaid beneficiaries may qualify for additional services and programs beyond what is available under Medicare. The federal government does mandate that states provide the following minimum benefits to Medicaid enrollees:

- Inpatient and outpatient hospital services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Transportation to medical care

If any of these services are also covered by a consumer's Medicare plan, Medicare will be the first payer for all or a portion of the expense; Medicaid then covers the balance or possibly any additional consumer out-of-pocket expenses.

6.2.2 Is staff able to refer older consumers to resources to assist them in understanding Medicaid benefits specific to your state?

The federal government allows states to elect to provide certain "optional" benefits to Medicaid enrollees. Additional potential benefits that may be provided through state Medicaid benefits:

- Prescription drug coverage
- Clinic services
- Rehabilitation therapies: physical therapy, occupation therapy, speech, hearing and language disorder services.
- Respiratory care services
- Additional diagnostic, screening, preventative and rehabilitative services
- Podiatry
- Chiropractic services
- Dental services and/or dentures
- Optometry services, including eyeglasses
- Prosthetics
- Private duty nursing services
- Hospice
- Case management
- Services for geriatric consumers in an institution for mental disease
- Services for the intellectual/developmentally disabled
- Home and community based services such as home-delivered meals, adult day health, chore service, personal care or self-directed personal assistance services
- Tuberculosis-related services

It is important for the IDT to be aware of all services that an older consumer may utilize and to discuss which services are critical to the care of the individual. The Kaiser Family Foundation provides information about which benefits are available in which states: <http://kff.org/data-collection/medicaid-benefits> as does the Aging and Disability Resource Center, see for example <http://dcoa.dc.gov/service/additional-resources-adrc>.

6.2.3 Can providers help older consumers understand which services may not be covered under your state's Medicaid programs?

Just as it is important to understand which services are covered under your state's Medicaid program, it is equally important to understand which services are not covered. It is critical for consumers to have a solid understanding of the health care costs they need to include in their personal budgets. Geriatric providers, through referrals to experts or through their own in-house knowledge, can assist the older consumer in being actively informed consumers of health care and long term services and supports.

6.3 Managed Care, Incentives and Value-Adds

In recent years many states have opted to deliver their Medicaid services and programs through managed care organizations (MCOs). These organizations are under contract with the state for the state's Medicaid enrollees. A majority of Medicaid enrollees in any one state may receive their benefits through an MCO, either voluntarily or because their state has mandated this process. Medicare Advantage (also known as Medicare Part C) gives beneficiaries the option of receiving their Medicare benefits through private health plans. While the majority of Medicare beneficiaries are covered by Original Medicare, close to a third were enrolled in a Medicare Advantage plan in 2015.²¹

Under the Financial Alignment Demonstration, CMS is testing models with States to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. By aligning financing between the two programs, CMS aims to support improvements in the quality and cost of care for enrolled individuals.

6.3.1 Does the provider understand the role of managed care and how to work with the managed care organization to facilitate optimal care and services for the older consumer?

The role of an MCO in a consumer's health plan will depend largely on his or her state's Medicaid regulations. More information can be found at your state's Medicaid website. Despite a particular state's regulations, MCOs are required by federal law to meet certain standards for consumers. Each managed care plan must provide a quality program with right to appeal and grievance for consumers. Consumers must also have reasonable access to providers and the right to change managed care plans if they so choose. Providers serving geriatric patients will have a solid understanding of the policies in place in their state because states have autonomy over some ways in which managed care plans are executed. For example, states may choose to mandate managed care plans in some regions and not others. States also have the authority to provide different benefits to consumers enrolled in a MCO. In states where MCOs are not mandated, a consumer may choose to receive services directly from the state.

6.3.2 Is the provider knowledgeable about 'value-adds' available to his/her older consumer from the consumer's managed care companies?

Some Medicaid and Medicare managed care organizations will provide extra services, benefits, or goods to consumers as an incentive for signing up with their organization. These are known as 'value-adds' or 'value-added services'. The benefits are in addition to what is covered by their Medicaid package and/or their Medicare package and are marketed as an additional value above what they would get if they were not a member of a MCO. These extra services may include dental coverage, weight loss programs, smoking cessation programs, prescription drug coverage, transportation for medical and non-medical purposes, career developmental services, vision services, and services for developmental disabilities, among others. Geriatric consumers

²¹ Kaiser Family Foundation: Medicare Advantage 06.29.2015 <http://kff.org/medicare/fact-sheet/medicare-advantage/>

will benefit from a provider's knowledge of the different managed care plans available in their state and the extra services offered by each plan.

6.3.3 Is the provider aware of incentives available from managed care companies for their members?

Incentives offered by a MCO can support geriatric providers as they encourage a healthy lifestyle for Medicare-Medicaid enrollees. MCOs may provide incentives to their members for activities and practices that promote a healthy lifestyle. They are aimed at promoting participation, engagement, and personal responsibility in one's own health care. One example of incentives is free gift cards for following through with routine checkups and preventative screenings. (Note that incentive rules may vary by state.)

6.4 Pharmaceutical Assistance

Prescription drugs can represent a significant portion of a consumer's health care spending. Older consumers in particular are often prescribed as many as 10 or 15 different drugs. Medicare and Medicaid may cover a portion of the costs, but Medicare-Medicaid enrollees may still be left with significant financial obligations. When prescribing to Medicare-Medicaid consumers, it is prudent for geriatric providers to consider costs that will be associated with the medical treatment plan.

6.4.1 Do providers understand what pharmaceutical assistance is provided under Medicare and Medicaid?

Many Medicare beneficiaries opt for Medicare Part D, which provides outpatient prescription drug coverage. For Medicare-Medicaid Enrollees, Medicaid assists with coinsurance costs and may cover Medicare-excluded medications in certain circumstances. Some states have expanded their Medicaid coverage to provide additional assistance for paying for prescription drugs; others have not. Medical management practices may exclude certain medications from coverage or limit the reimbursement for certain brand names through their pharmaceutical protocols. More information about a state's particular prescription drug coverage can be found on your state's Medicaid website or the federal government's Medicaid website.²²

6.4.2 Do providers consider Medicare Part D drug coverage when developing treatment plans?

Medicare Part D does not cover all prescription drugs. Non-generic drugs are rarely covered under Part D, although consumers can appeal for special coverage. A list of excluded drugs can be found online.²³

6.4.3 Do providers optimize therapeutic strategies that do not rely on pharmaceuticals?

Geriatric-competent providers maximize all therapeutic strategies and recognize that both under-treatment and over-treatment are common issues in geriatric prescribing. Optimizing non-drug therapies may reduce the need or dosage requirement for some medications. Geriatric primary care and nursing texts offer expert guidance on therapeutic strategies for common geriatric conditions and syndromes. If pharmaceuticals are used, geriatric-competent providers reference unbiased publications that compare costs and clinical outcomes for medications in the same therapeutic class. Consultation with geriatricians and geriatric pharmacists provides additional expertise in optimizing or simplifying complex medication plans, reducing polypharmacy and/or weighing risks, benefits and trade-offs (clinical and financial) of various options.

²² Medicaid.gov. State Prescription Drug Resources. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/State-Prescription-Drug-Resources.html>

²³ Centers for Medicare and Medicaid Services. Part D Drugs/Part D Excluded Drugs. Retrieved from <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PartDDrugsPartDExcludedDrugs.pdf>.

6.4.4 Does the provider know of, and facilitate the knowledge by the older consumer of, additional financial assistance available from pharmaceutical companies?

Some pharmaceutical companies will offer additional financial assistance for consumers with limited incomes. Consumers must meet eligibility requirements and assistance may only be offered for certain products. For example, Pfizer has established Pfizer Rx Pathways that offers insurance counseling, co-pay help, and free or discounted medicines. The pharmaceutical operating companies of Johnson & Johnson offer special financial assistance to low-income enrollees in Medicare Part D. Geriatric providers with knowledge of these assistance programs are better equipped to help consumers get the medications they need for proper care.

7 FINANCIAL AND LEGAL ISSUES

Consumer-centered care recognizes the importance of addressing non-health care challenges in consumers' daily lives that impact their overall well-being. Medicare-Medicaid eligibility is based on the consumer's age and/or disability status, and poverty level. Organizations with geriatric competency recognize the harmful effect that financial burdens may have on the older consumer and are able to be a resource-link for their consumers or facilitate the right person to help.

Organizations with high levels of geriatric care are also aware of the legal issues that Medicare-Medicaid enrollees encounter. Advanced directives are important at all stages of life, but are especially critical for the elderly and disabled. The same is true for power of attorney documents and advocacy assistance. Organizations with geriatric capacity are a key referral resource for consumers with legal needs, including living wills, powers of attorney, guardianships (also known as conservatorships in some states), and grievance disputes. Elder law attorneys can also be a valuable resource for information regarding pooled, disability, or special needs trusts that may pay for services and supports not funded by Medicare or Medicaid.

7.1 Financial and Environmental Support

Medicare and Medicaid pay for the majority of health care expenses for enrollees; however, the financial needs of the Medicare-Medicaid enrollee population are much broader in scope than just those related to health care goods and services. Additional financial supports are often needed to enhance quality of life and aspects of life that contribute to the well-being of the consumer. Although many of these supports are technically outside of the health care realm, an organization with high levels of geriatric capacity is a useful resource in connecting the consumer with external financial supports and services. Organizations with geriatric capacity assess financial well-being and refer the consumer to a professional (e.g., social worker, care manager) who can do a comprehensive assessment and ensure that all existing state and federal financial supports are being optimized. Programs such as the Supplemental Nutritional Assistance Program (SNAP), the Medicare Savings Program and state supplements may enable scarce dollars to be used for other types of services and supports and expand the capacity of the IPC to meet needs. Veteran's benefits and tax relief should also be explored. Social service professionals and care managers may also be aware of local and regional charitable foundations that provide specific types of material or financial assistance.

7.1.1 Is the IDT aware of resources or resource points of contact to assist consumers with transportation that is not medically related?

Non-medical transportation services are not covered by Medicare or Medicaid. However, safe and accessible transportation are important for older consumers' quality of life. For example, an older consumer may want to go to church or need to go grocery shopping. An organization with geriatric capacity is knowledgeable about transportation resources, including Area Agencies on Aging (AAAs) and other local contacts for free or low-cost senior transportation, e.g., city and state departments may offer programs with volunteer drivers to assist the elderly in the community with rides or with discounted or free public transportation coupons.

7.1.2 Is the IDT aware of resources or points of contact for resources to assist geriatric consumers with housing and utilities?

Organizations with geriatric capacity ensure that staff are knowledgeable or have formal contact with a person or entity knowledgeable about housing and utilities assistance available to consumers. Examples of housing and utilities resources include:

- US Department of Housing and Urban Development (HUD)
 - Section 202 Supportive Housing for the Elderly
 - Section 231 Mortgage Insurance for the Elderly
 - Housing Choice Vouchers (rental assistance)
- US Department of Agriculture (USDA)
 - Section 504 Rural Housing Repair and Rehabilitation Grants
 - Section 502 Rural Housing Loans
 - Section 521 Rural Rental Assistance
- Low Income Home Energy Assistance Program (LIHEAP)

Information about housing, utilities, pest management, pet care and other housing/environment related issues may be accessed through state and local AAAs, ADRCs, Certified Professional Geriatric Care Managers, and others. Information about tax credits and tax relief programs may be available from the tax assessor.

7.1.3 Is the IDT aware of resources or points of contact to assist consumers with meals or nutritional supplements?

Organizations with geriatric capacity ensure that staff are knowledgeable or have formal contact with a person or entity knowledgeable about food and nutrition resources for consumers with low or fixed incomes. Examples include

- Commodity Supplemental Food Program
- Senior Farmers' Market Nutrition Program (SFMNP)
- Community-based organizations funded through government grants and private donations to provide congregate and home-delivered meals (e.g., Meals on Wheels and Senior Centers)
- Food banks

7.1.4 Is the IDT aware of resources to assist older consumers with other services, supports, and incidentals that are generally not covered by Medicare, Medicaid, and other Home and Community Based Services (HCBS)?

This category includes activities such as assistance with housekeeping, grocery shopping, yard work and other light maintenance tasks at a consumer's residence. Organizations with high levels of geriatric capacity have staff aware of, or have a contact person that knows of resources to assist with the older adults' daily needs that are in addition to medical care. These types of resources may be found through AAAs/ADRCs, Certified Professional Geriatric Care Managers, Geriatric Social Workers, local faith-based organizations, and by contacting the local 2-1-1 call center.²⁴

7.1.5 Is the IDT aware of condition-specific resources that may assist older consumers and their caregivers to meet their financial needs?

The IDT should also be aware of resources for consumers and caregivers to help cover costs of care that fall outside of traditional medical costs.^{25,26} Examples include:

²⁴ 2-1-1 provides free and confidential information and referral for help with food, housing, employment, health care, counseling, and more. www.211us.org

²⁵ National Institute on Aging: Legal, Financial, and Health Care Planning Documents. <https://www.nia.nih.gov/alzheimers/publication/legal-and-financial-planning-people-alzheimers-disease-fact-sheet#legal>

²⁶ Alzheimer's Association: Money Matters. http://www.alz.org/national/documents/brochure_moneymatters.pdf

- Claiming the “Child and Dependent Care Credit” on the federal income tax return
- Workplace flexible spending account (FSA) to pay for out-of-pocket medical expenses and dependent care expenses with pretax dollars
- Many states have additional tax deductions or tax credits to provide financial relief to caregivers

Other resources to help caregivers make financial decisions are also available, including a series of free booklets produced by the Consumer Financial Protection Bureau, “Managing Someone Else’s Money.”²⁷

²⁷ Consumer Financial Protection Bureau: Managing Someone Else’s Money.
<http://www.consumerfinance.gov/blog/managing-someone-elses-money/>

7.2 Legal Issues

7.2.1 Guardianship and Incapacity Determination²⁸

7.2.1.1 Does the IDT understand the legal process for determining if a consumer is incapacitated and requesting the appointment of a guardian?

Guardianship (also known as conservatorship in some states) definitions and regulations vary by state and situation. In general, a guardian (or conservator) of the person possesses some or all power over the consumer's personal affairs (health and welfare). A guardian of the estate possesses some or all power with regard to the consumer's personal property. Due to the seriousness of losing one's individual rights when declared incapacitated, guardianships are considered an option of last resort and require that a court first deem an individual incapacitated. This determination is not clear-cut, as an individual may have periods of lucidity between periods of confusion. The court must take into account the individual's functional capability in a variety of settings. Voluntary or temporary conservatorship may be useful in some circumstances.

7.2.1.1 Are there protocols in place to ensure continuity of care for the consumer in the event that a guardian is appointed?

An organization with geriatric capacity familiarizes staff with protocols that will ensure that consumers do not suffer interruptions in care should a guardian be appointed. Protocols may include verification of court documents as well as the guardian's identity, and an in-person meeting to discuss the IPC with the guardian.

7.2.2 Ombudsman

An ombudsman is an individual who assists consumers in resolving problems they may have with their health care payers, skilled and residential nursing homes, and assisted living facilities. An ombudsman is a neutral party who works with the consumer, the organization or facility, and the provider (as appropriate) to resolve individual consumer complaints, grievances, appeals, and inquiries. Ombudsman programs vary by state.

7.2.2.1 Is the IDT able to help consumers connect with their ombudsman to resolve problems with their payer or long-term care facility?

An organization with geriatric capacity is aware of and is able to refer older consumers to their local ombudsmen in order to resolve the consumers' concerns in a timely manner.

²⁸ By definition, to be incapacitated means to lack the mental or physical capacity to sufficiently care for person and property whether temporarily, intermittently or permanently. The term is often used interchangeably with the word "incompetent," although the former traditionally describes medical status while the latter is a legal finding. However, most states use the term "legally incapacitated" to describe someone who is unable to meet basic requirements to preserve physical health and safety. Excerpt from: Maier, K. Legally Incapacitated vs. Legal Incompetent. Demand Media. Retrieved from <http://info.legalzoom.com/legally-incapacitated-vs-legally-incompetent-21238.html>

7.2.3 Advance Directives

An advance directive is a legal document that goes into effect only if the consumer is incapacitated and unable to speak for him- or herself. There are two elements in an advance care directive—a living will and a durable power of attorney for health care. Additionally, some states also have statutes that allow for a durable power of attorney for mental health care which may also be referenced as a Psychiatric Advance Directive (PAD).^{29,30} Those directives allow a power of attorney to make decisions about mental health treatment without requiring determination of incapacity.

7.2.3.1 Does IDT staff know whom to contact or refer the older consumer to, for assistance with a living will, durable power of attorney for health care, and/or durable power of attorney for mental health care?

Organizations with high levels of geriatric capacity have staff with knowledge of advance directives, as well as the ability to direct the consumer on how to obtain guidance and legal advice when completing the following items:

- Living will: a written document that specifies the end-of-life care the consumer wishes to receive.
- Durable power of attorney for health care: a legal document naming the consumer's health care proxy. This proxy will make the consumer's medical decisions should the consumer be unable to do so. A power of attorney does not override the wishes of a consumer who is able to manage their own affairs.
- Durable power of attorney for mental health care: a legal document naming the consumer's mental health care proxy. If a licensed practitioner (some states specify a psychiatrist or psychologist) deems the consumer incapable of giving informed consent, the proxy will make decisions about mental health care.

7.2.3.2 Does the IDT know how to assess the appropriate time to institute a living will, durable power of attorney for health care, or durable power of attorney for mental health care?

Licensed medical practitioners adhere to their medical training when following directives in a living will and gauging the appropriate time to defer care decisions to a power of attorney for health or mental health care. Staff at non-clinical organizations with geriatric capacity may have

²⁹ A Psychiatric Advance Directive (PAD) is a legal document written by a competent person who lives with a mental illness. It describes the person's mental health treatment preferences, and/or names an agent to make treatment decisions for the individual, should he or she become unable to make such decisions due to psychiatric illness. Excerpt from: National Alliance on Mental Illness. Policy Topics. Psychiatric Advance Directives: An Overview. Retrieved from http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=137779

³⁰ Mental health advance directives are similar to the more commonly used directives for end-of-life medical decisions. An individual must be competent to execute a mental health advance directive, and the directive must clearly express the patient's wishes. Once directives are executed, steps must be taken to ensure compliance, including adequate dissemination to providers, and to ensure that proxy decisions are consistent with the patient's treatment preferences. Excerpt from: Substance Abuse and Mental Health Services Administration (SAMHSA). Homelessness Resource Center. Advance Directives for Mental Health Treatment.

protocols in place that direct the process of connecting the consumer to the appropriate medical or mental health assessment, if conditions make it likely that a proxy for health care decision-making is necessary.

7.2.4. Health Insurance Portability and Accountability Act

Although many aspects of HIPAA are important to an organization with high levels of geriatric capacity, this section highlights components that deal most directly with consumer interaction, which is Title II.³¹ Title II regulates privacy and security of individuals' Protected Health Information, the use and dissemination of electronic health care records, and programs to rights and protections, including controls over how their information is used and disclosed, the right to examine and obtain a copy of their health records, and the right to request corrections.³² Ensuring strong privacy protections is critical to maintaining consumers' trust: an integral part of being competent in geriatric care.

7.2.4.1 Are IDT staff knowledgeable about HIPAA Title II regulations regarding consumer PHI?

Organizations with high levels of geriatric capacity have IDT staff that are well informed about HIPAA privacy and security regulations. Staff understand their responsibility to adhere to the regulations and do not break this confidentiality. IDT staff follow organization protocols to prevent the unauthorized release of consumers' PHI and understand processes to report and correct any privacy violations.

7.2.4.2 Do IDT staff honor and facilitate the release of PHI to the consumer?

The HIPAA Privacy Rule allows use and disclosure of information for treatment and other purposes with appropriate protections.⁹ Geriatric-competent IDT staff are aware of these circumstances, are able to inform consumers of their rights to their health information, the consumer's right to release information to family and other designated individuals, and are able to take the necessary steps to provide the information to consumers. Staff have Release of Health Information and Release of Medical Records documents available for the consumer to complete. State laws may also include additional protections for PHI related to psychiatric diagnosis and treatment and/or HIV/AIDS.

³¹ Title I of the Health Insurance Portability and Accountability Act (HIPAA) regulates health care access, portability, and renewability.

³² U.S. Department of Health and Human Services. HIPAA Privacy Rule and Sharing Information Related to Mental Health. <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html>

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.³³ 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

³³ 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.³⁴ 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.

³⁴ 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)³⁵
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)³⁶
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:

³⁵ 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/>

³⁶ 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 environment³⁷

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.

³⁷ 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.³⁸ 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

³⁸ 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 Visit³⁹
- 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

³⁹ 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

1. Relational-based Care Management

- **Patient-Centered Primary Care Collaborative:**
<http://www.pcpcc.org/>
- **Patient-Centered Care:**
<http://pcmh.ahrq.gov/page/patient-centered-care>
<http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/>
- **Relational-Based Care:**
<http://chcm.com/relationship-based-care/>
- **Basic cognitive assessment tools:**
<http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp#patientassesstools>
- **Collaboration for Homecare Advances in Management and Practice (CHAMP):**
Advancing Home Care Excellence. Geriatric Care Transitions Toolkit: <http://www.champ-program.org/page/100/geriatric-care-transitions-toolkit>
- **The Alzheimer's Association offers many tips and guidelines for caregiver resources:**
<http://www.alz.org/care/alzheimers-dementia-care-training-certification.asp>

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>

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>

4. Alternate Living Arrangements

- **Residential Facilities:** <http://store.samhsa.gov/shin/content//SMA06-4166/SMA06-4166.pdf>
- **Substance Abuse:** <http://www.ncbi.nlm.nih.gov/books/NBK64409/>
- **Alternative Living Arrangements:** <http://www.medicare.gov/nursing/alternatives/other.asp>
- **Board and Care Homes:** <http://aspe.hhs.gov/daltcp/reports/1993/rn06.htm>
- **State Veterans Homes:** http://www.va.gov/geriatrics/guide/longtermcare/State_Veterans_Homes.asp#
<http://www.socialwork.va.gov/socialworkers.asp>
<http://www.nasvh.org/StateHomes/statedir.cfm>
- **Board and Care Homes:** <http://www.vda.virginia.gov/boardandcare.asp>
- **Residential Nursing Facilities:** <http://www.medicare.gov/nursinghomecompare/search.html>.
- **Nursing Homes:** <http://www.medicare.gov/NursingHomeCompare/checklist.pdf>

5. Caregiving

- **Nursing Care of Older Adults:**
http://www.aacn.nche.edu/geriatric-nursing/aacn_gerocompetencies.pdf
- **Care of the Family Caregiver:**
<http://www.caregiving.org/pdf/resources/CFC.pdf>
- **Caregiving Resources:**
<http://www.aarp.org/home-family/caregiving/>
- **Kinship Care:**
<https://netforum.avectra.com/eweb/DynamicPage.aspx?Site=cwla&WebCode=Kinship14>
- **Alzheimer's Association: Respite Care:**
<https://www.alz.org/care/alzheimers-dementia-caregiver-respite.asp>
- **National Institute on Aging: "Caring for a Person with Alzheimer's Disease"**
<https://www.nia.nih.gov/alzheimers/publication/caring-person-alzheimers-disease/about-guide>
- **Family Caregiver Alliance: Dementia with Lewy Bodies**
<https://caregiver.org/dementia-lewy-bodies>

6. Benefits and Resources

- **Medicare-Medicaid Enrollees:**
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html>
- **ACA and Medicare-Medicaid Enrollees:**
<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8192.pdf>
- **Medicare Supplements:**
<http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>
- **Medicaid Benefits:**
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>
- **Managed Care Organizations:**
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>
- **Incentives and Value Adds:**
http://www.kancare.ks.gov/health_plan_info.htm
- **Prescription Drug Coverage:**
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/State-Prescription-Drug-Resources.html>

- **Prescription Drug Coverage:**
<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PartDDrugsPartDExcludedDrugs.pdf>

7. Financial and Legal Issues

- **Advance Care Planning:**
http://www.nia.nih.gov/sites/default/files/advance_care_planning_tipsheet_0.pdf
- **Medicare Beneficiary Ombudsman:**
<http://www.medicare.gov/Pubs/pdf/11173.pdf>
- **End-of-Life Decisions:**
http://www.caringinfo.org/files/public/brochures/End-of-Life_Decisions.pdf
- **Guardianship:**
http://www.guardianship.org/reports/Guardianship_of_the_Elderly.pdf
- **Elderly Housing:**
<http://www.gao.gov/new.items/d05174.pdf>
- **Health Information Privacy:**
<http://www.hhs.gov/ocr/privacy/>
- **HIPAA:**
<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/HIPAAGenInfo/>
- **National Institute on Aging: Legal, Financial, and Health Care Planning Documents.**
<https://www.nia.nih.gov/alzheimers/publication/legal-and-financial-planning-people-alzheimers-disease-fact-sheet#legal>
- **Alzheimer's Association: Money Matters.**
http://www.alz.org/national/documents/brochure_moneymatters.pdf
- **Consumer Financial Protection Bureau: Managing Someone Else's Money.**
<http://www.consumerfinance.gov/blog/managing-someone-elses-money/>

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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