

Geriatrics-Competent Care: An Introduction

This brief highlights introductory information from Resources for Integrated Care's webinar *A Discussion of Universal Competencies that are Fundamental to Quality Geriatrics Care Across Disciplines and Care Settings* presented by Gregg Warshaw, MD, Kyle Allen, MD and W. June Simmons, MSW. This information includes:

- understanding what is unique about the health, care and assessment of older adults
- prevention, diagnosis and management of geriatric syndromes
- care transitions
- medication management
- maintaining older adults' function and well-being
- working with older adults and families to set care goals
- coordinating care with interdisciplinary teams
- providing social services and supports

What is Unique about the Health, Care and Assessment of Older Adults?

The older adult population is diverse and varies considerably in terms of physiology, function and culture. Thus, individualized care rather than protocol-based care is especially important for this age group. Aging, in and of itself, is not a disease and does not generally cause symptoms. Aging occurs at different rates among individuals and over time for a given person. Aging is associated with decline in normal function that stems equally from four areas: disease, misuse, disuse, and physiological changes as an individual grows older. As a result, function (not disease diagnosis) is the most critical focal point of geriatric assessment. As part of a complete geriatric assessment, it is important to identify functional deficits that adversely affect an individual's prognosis and quality of life.

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There are six core principles of geriatric assessment:

Goal: Promote wellness and independence

Focus: Function and performance (i.e. gait, balance, transfers)

Scope: Physical, cognitive, psychological and social domains

Approach: Multidisciplinary

Efficiency: Ability to perform rapid screening to identify target areas

Success: Maintaining or improving quality of life

Proper care planning after assessment includes working with both the older adult and her or his family to determine the right amount of care and the right care setting to achieve the person's care goals. This type of careful care planning and integration is crucial because acting hastily can often do more harm than not acting at all. Care decisions need to be paced so that the individual, the family and the clinician have adequate time to evaluate all of the options before proceeding. It is for this reason that inter-professional team care is essential to providing optimal care for older adults. In fact, interdisciplinary care teams are a requirement of the health plans in the [financial alignment demonstration](#) projects to integrate care for Medicare-Medicaid beneficiaries.¹

Prevention

There are several preventative measures that may help reduce disease and functional decline among older adults.

Immunizations and screening tests can be recommended to older adults based on their remaining life expectancy and cognitive status. In addition, regular wellness exams are important in providing geriatric assessment, medication management and care planning. Fortunately, the new Medicare benefit provided by the Affordable Care Act pays for an annual wellness visit and helps to cover these options for older adults free of cost.

Physical activity is also important in preventing disease and functional decline. Physical activity promotes mobility and reduces rates of frailty, heart disease and osteoporosis. The best physical activity programs include a mix of exercises that promote the following:

- Flexibility (e.g., stretching)
- Endurance (e.g., walking or cycling)
- Strength (e.g., weight training)
- Balance (e.g., Tai Chi or dance)

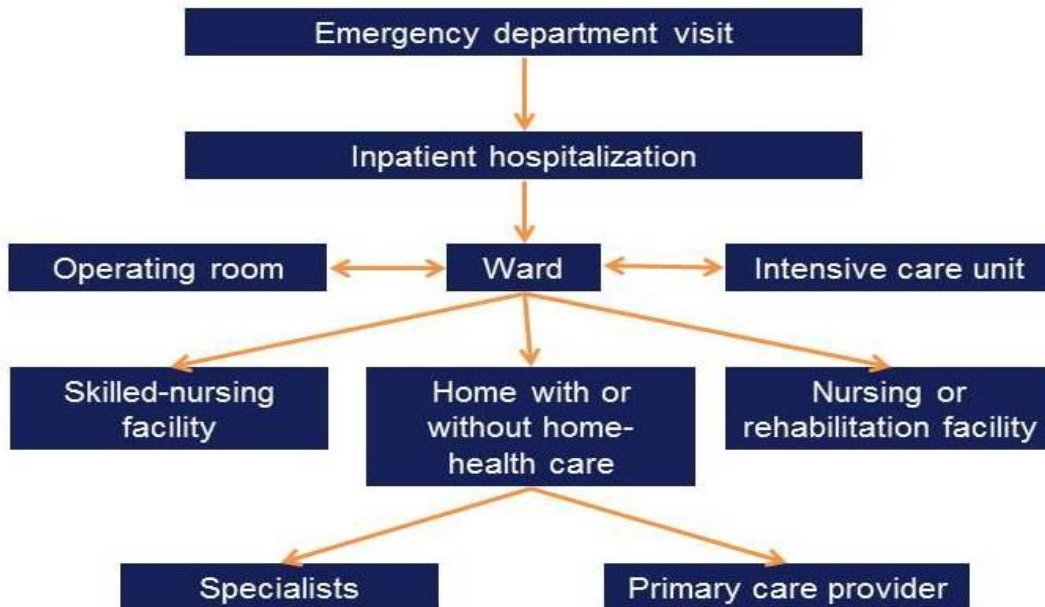
Another crucial aspect of proper care is preventing iatrogenic illness (illness caused by medical examination or treatment). Illness caused by medical interventions is one of the most common, yet preventable, medical problems for older people. Thus, the risks and benefits of diagnostic tests and treatments must be reviewed carefully between older individuals, their caregivers when appropriate, and their providers in order to avoid iatrogenic illness.

¹ Financial Alignment Demonstration: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

Risk of Care Transitions

Care transitions refer to the transferring of care from one provider or setting to another. For example, care transitions might include going from the emergency room to inpatient hospitalization to a skilled nursing facility. Often it entails the physical transfer of a patient, but it may also mean transitioning from one health care provider to another.

Common Care Transitions



Care transitions have the potential to lead to misunderstandings of diagnoses and treatment plans, medication discrepancies, and confusion on the part of patients and families. Many older adults have limited physiologic reserves, putting them at risk of bad outcomes during poorly handled transitions. Therefore, it is critical to properly assess the risks and benefits of each care transition before taking action. This is particularly important if an older adult is being discharged from the hospital to home where it will be necessary to maintain proper care outside of a medical setting.

Safe Medication Use for Older Adults

Many medications have not been tested specifically with geriatric populations and, as a result, the safety and effectiveness of their usage with older adults may not be fully understood. In addition, taking multiple medications and having multiple health problems (both common circumstances among the geriatric population) has potential to lead to adverse drug interactions and outcomes. Therefore, it is beneficial to have one clinical provider who takes charge of all medications for an older adult and engages in a periodic review of prescribed medications, over-the-counter medications and supplements, to make sure they remain safe and effective. The ultimate goal is to prescribe as few medications as possible.

Important Questions to Consider When Prescribing Medications

- Is this medication necessary?
- What are the therapeutic end points?
- Do the benefits outweigh the risks?
- Is this medication used to treat effects of another drug?
- Could one drug be used to treat two conditions?
- Could this medication interact with diseases or other drugs?
- Does patient know what the medication is for, how to take it, and what adverse side

Understanding Geriatric Syndromes

Over 50 percent of older adults have at least three chronic illnesses. Having multiple chronic illnesses is associated with higher mortality rates, disability, adverse outcomes, institutionalization, greater use of health care resources and poorer quality of life. Among the most significant geriatric syndromes are: falls, gait/balance problems, dizziness, weakness, frailty, incontinence and confusion. Falls are particularly common among older adults and are an important focus for prevention.

Factors Affecting Fall Risk

- History of falls
- Medications
- Visual acuity
- Gait, balance, and mobility
- Muscle strength
- Neurological impairment
- Heart rate and rhythm
- Postural hypotension
- Foot problems and footwear
- Environmental hazards

Complications stemming from falls are the leading cause of death among individuals 65 and older. The annual incident rate of falling is approximately 60 percent among older adults with a history of falls. Fortunately, fall risk can be readily assessed with an eye toward prevention by asking older adults about recent falls and checking for gait and balance disturbances as part of annual wellness exams. An interdisciplinary approach can then be taken to prevent falls by aiming to reduce intrinsic and environmental risk factors such as tripping hazards in the home or neighborhood. It is critical to remain vigilant about factors that affect fall risk.

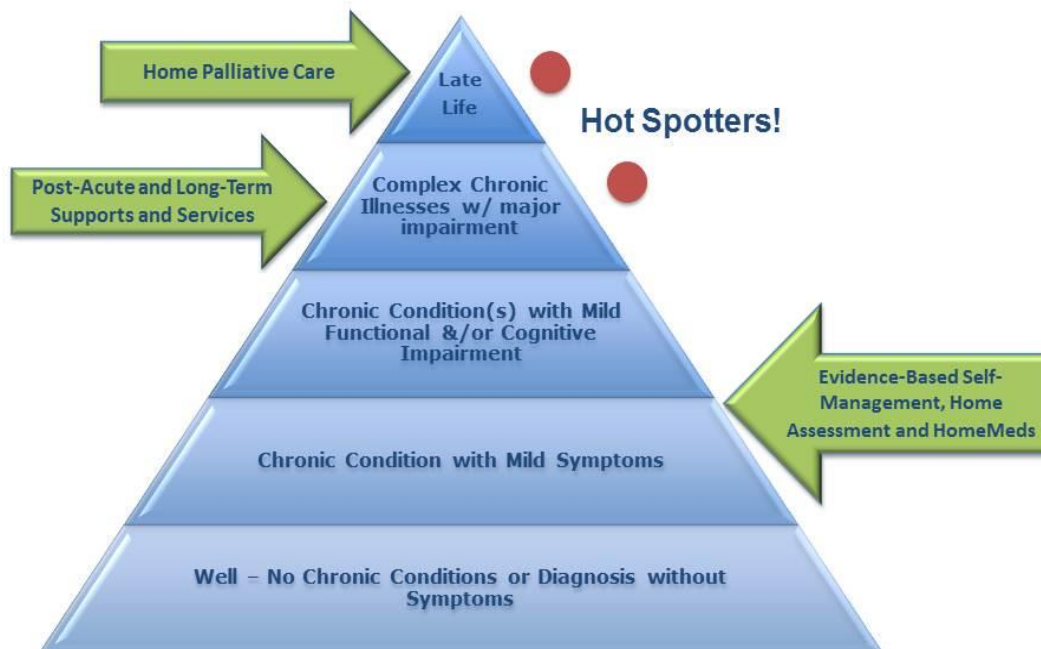
Social Services and Supports: Bringing Medicine, Families and Community-Based Services Together

There are many community-based agencies that provide services for older adults. The starting place for identifying needed services is a psychosocial and environmental assessment in order to identify home risk factors. This includes assessing function, fall risk, depression, cognitive

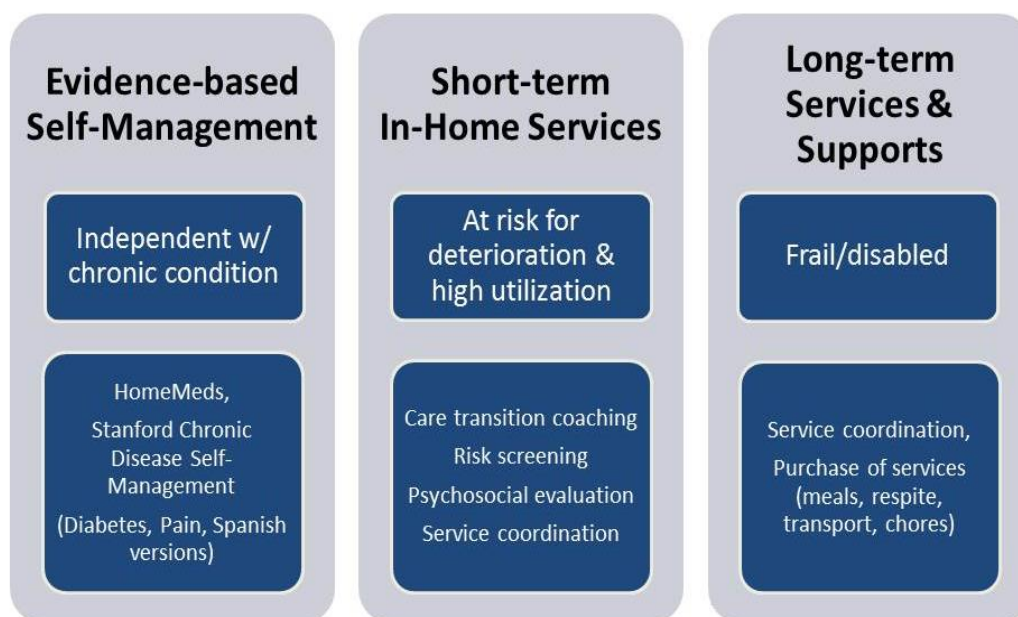
impairment, home and neighborhood safety, barriers to treatment, economic stability, and level of social support and services. Consequently, social workers can be the “eyes and ears” in identifying unmet needs and facilitating access to a whole host of social services and evidence-based self-management programs for older adults and their caregivers that address social determinants of health.

Focusing on building community partnerships between clinical care and social services can help improve health outcomes for adults with chronic conditions through comprehensive, coordinated and continuous expert and evidence-based services. Community-based social service organizations have the ability to take more time to probe into older adults’ situations while incorporating high levels of cultural competency, lower-cost staff and infrastructure, and high-impact evidence-based self-management programs. This allows for a more holistic, pro-active style of care that can address lifestyle change as well as manage disease risks effectively. In addition, it is important to target particular geriatric populations and common risks among this age group such as functional limitations, dementia, frailty, chronic illness and hospital/emergency room use.

Targeted Patient Population Management with Increasing Disease/Disability



Services Targeted to Individual Needs



Targeting services to an individual's needs is an important step in providing adequate care. For individuals who are independent but have a chronic condition, evidence-based interventions that encourage self-management may be sufficient for meeting their care needs. Others may require short-term in-home services, particularly following a hospitalization. Such services can bring stabilizing in-home support and may reduce post-acute 30-day ER and hospital use. Finally, incorporating long-term services and supports for individuals who are particularly frail or have disabilities can increase service coordination, which may help make sure people are in their own home.

Home and community-based services have been shown to improve quality of life among older adults by helping keep them in their homes while also reducing costs. For example, in a [study of Medicare enrollees at high risk of hospital readmissions](#), a social work in-home coaching program that identified medication issues as well as falls risks was shown to dramatically reduce emergency room usage and hospital readmissions.² This study reinforces the need to apply the principles of geriatric-competent care and to forge partnerships among health care providers, home and community-based providers, consumers and advocates. Applying these principles can help achieve better health and greater care at a lower cost.

Additional Resources

- Resources for Integrated Care - Geriatrics-Competent Care Webinar https://www.resourcesforintegratedcare.com/Webinar1_Introduction_To_Geriatrics_Compentent_Care

² Community-based Care Transitions Program <http://innovation.cms.gov/initiatives/CCTP/?itemID=CMS1239313>

- Centers for Medicare & Medicaid Services - Resources for Integrated Care Available for Health Plans & Providers
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ResourcesforIntegratedCareAvailableforHealthPlansandProviders.html>
- Position Statement on Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Health Care for Older Adults
http://www.americangeriatrics.org/files/documents/Full_IDT_Statement.pdf
- Administration on Aging (Administration for Community Living) - Aging & Disability Evidence-Based Programs and Practices
<http://acl.gov/Programs/CDAP/OPE/ADEPP.aspx>
- National Association for Social Workers - Standards of Practice
<http://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf>
- Healthy Living Center for Excellence - Evidence-Based Self-Management Programs
<http://www.healthyliving4me.org/programs/>
- National Council on Aging - Evidence-Based Programs
<http://www.ncoa.org/improve-health/center-for-healthy-aging/>
- Eldercare Workforce Alliance, Quality Care through a Quality Workforce
http://www.eldercareworkforce.org/files/DUALS/EWA_Duals_Toolkit_-_FINAL_v1_-_October_2014.pdf
- Medicare.gov, Preventive visit & yearly wellness exams
<http://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html>
- Community Catalyst - *Voices for Better Health*
<http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health>

About the Webinar Series

Resources for Integrated Care (RIC) supports plans and providers in their efforts to **deliver more integrated, coordinated care to Medicare-Medicaid enrollees**. RIC represents the collaboration between the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), The Lewin Group and the Institute for Healthcare Improvement.

The RIC webinar, *A Discussion of Universal Competencies that are Fundamental to Quality Geriatrics Care Across Disciplines and Care Settings*, was supported through the MMCO in the CMS to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series. To learn more about current efforts and resources, visit Resources for Integrated Care at www.resourcesforintegratedcare.com for more details.