Geriatric Services Capacity Assessment User Guide

September 2024

Table of Contents

Abbreviations

AAA: Area Agencies on Aging

ACL: Administration for Community Living

ACP: advance care plan

ADE: adverse drug event

ADL: activities of daily living

ADRC: Aging and Disability Resource Center

ADRD: Alzheimer's disease and related dementias

ASL: American Sign Language

CBO: community-based organization

CMS: The Centers for Medicare & Medicaid Services

D-SNP: Dual Eligible Special Needs Plan

ED: emergency department

EHR: electronic health record

GSCA: Geriatric Services Capacity Assessment

HCBS: home and community-based services

HRSA: Health Resources & Services Administration

HIPAA: Health Insurance Portability and Accountability Act

IADL: instrumental activities of daily living

IDT: interdisciplinary care team

LTC: long-term care

LTSS: long-term services and supports

MA: Medicare Advantage

MCO: managed care organization

MMCO: Medicare-Medicaid Coordination Office

NCD: national coverage determination

NIA: National Institute on Aging

NP: nurse practitioner

PAD: psychiatric advance directive

PCA: personal care assistant

PCP: primary care practitioner

PHI: protected health information

QI: quality improvement

RIC: Resources for Integrated Care

SDOH: social determinants of health

SNF: skilled nursing facility

VA: Department of Veterans Affairs

A. Pre-Assessment Background and Framing

Health care organizations can use this Geriatric Services Capacity Assessment (GSCA) User Guide and Tool to evaluate and enhance their readiness in addressing the care needs of older adults—particularly those dually eligible for Medicare and Medicare. The Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) and Resources for Integrated Care (RIC) published the initial GSCA User Guide and Tool in 2016. The intersecting fields of person-centered care, health equity, and geriatrics—what RIC calls "geriatric-competent care"—have since advanced considerably. MMCO and RIC updated the GSCA User Guide and Tool in 2024 to offer health plans, systems, and providers— particularly those caring for dually eligible individuals—the most current evidence-based strategies for providing high-quality geriatric-competent care. This revised GSCA User Guide (i.e., this PDF document) and the corresponding GSCA Tool (i.e., Excel document) offer an easier-to-use assessment that can help support improvements to the quality of care for older adults.

Providing Geriatric-Competent and Person-Centered Care

The Case for Improving Quality and Equity for Older Adults

Older adults are a large and fast-growing demographic. The number of Americans age 65 and older ("older adults") grew from 40 million in 2010 to nearly 56 million in 2021, or from 13 percent to nearly 17 percent of the total population. The U.S. Census Bureau projects that the older adult population will surpass that of children and adolescents within the next two decades.[1]

Simultaneously, the older adult population is growing more racially and ethnically diverse; 24 percent of individuals age 65 and older identified as non-White in 2020, up from 18 percent in 2004.[2,3] Given that non-White populations continue to experience poorer health compared with their White counterparts and that aging is correlated with increased disease burden, these evolving demographics hold significant implications for the health care delivery system.[4,5] Such trends suggest a need for health plans, systems, and providers to include in their continuous quality improvement (QI) efforts strategies that engage older individuals and their caregivers.

In 2021, the American Geriatrics Society updated its list of geriatric competencies to improve health equity while making person-centered and coordinated care a standard practice.[6] It recognizes that collaborative relationships between older individuals and their clinicians, care coordinators, and other supports[7] can improve older adults' outcomes and quality of life while also reducing costs.[8,9,10,11,12] Geriatric-competent care reflects a commitment to person-centeredness, health equity, and a deep understanding of older adults' health needs.

> **What Is Person-Centered Care?**
>
> "Integrated health care services delivered in a setting and manner that are responsive to individuals and their goals, values, and preferences is a system that supports good provider-patient communication and empowers individuals receiving care and providers to develop and implement effective care plans together . . . [By providing] health care providers with this big-picture information, they are better equipped to develop care plans that include empathy, dignity, and respect with patients, their families, and other caregivers."
>
> *– The Centers for Medicare & Medicaid Services*

> **What Is Geriatric-Competent Care?**
>
> Care that reflects a commitment to person-centeredness and health equity, coupled with a deep understanding of the unique health needs of older adults.
>
> *– Resources for Integrated Care*

> **Why Dually Eligible Individuals Benefit from Person-Centered Care**
>
> Of the more than 12 million dually eligible individuals, 4.8 million live with disabilities and 7.2 million are low-income seniors.[13] Between 2006 and 2019, the total number of dually eligible individuals increased from 8.6 million to 12.3 million, an average annual growth rate of 2.8 percent.[14] These individuals might benefit from person-centered health care for several reasons.
>
> First, compared with the general Medicare population, dually eligible older adults tend to have more chronic health conditions and are more likely to live with disabilities.[15] Roughly 25 percent of dually eligible individuals have five or more chronic conditions, compared with only 15 percent of Medicare-only individuals.[16] They also disproportionately experience hospitalizations for ambulatory care-sensitive conditions that, with proper primary and preventive care, might have been unnecessary.[17] Person-centered, geriatric-competent care can help support appropriate preventive care, which can improve individuals' health outcomes.[18]
>
> Second, high disease burden, particularly among dually eligible older adults, often translates into high costs. In 2021, dually eligible adults age 65 and older represented:
>
> - Twelve percent of Medicare enrollees and 22 percent of Medicare spending and
> - Eight percent of Medicaid enrollees and 17 percent of Medicaid spending.[19]
>
> That same year, dually eligible individuals age 65 and older represented $311.1 billion in combined Medicare and Medicaid spending, contrasted with $182.3 billion for dual enrollees age 64 and younger.[20] Enhancing proficiency in caring for older adults using a person-centered approach presents an opportunity to reduce costs and enhance both care quality and associated health outcomes for aging individuals.

Implications for Health Equity

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."[21] Despite a growing focus on improving health equity, disparities persist. For example, compared with non-Hispanic White people, Black people receive worse care on 52 percent of quality measures that the Agency for Healthcare Research and Quality (AHRQ) tracks in its annual National Healthcare Quality and Disparities report; American Indian and Alaska Native, Hispanic, and Asian people receive worse care on 44 percent, 37 percent, and 35 percent of measures, respectively.[22]

These disparities disproportionately affect the dually eligible population, which is significantly more diverse than the Medicare-only population. In 2021, the proportion of dually eligible individuals who were Black (21 percent) and Hispanic (18 percent) was higher than the corresponding proportions of their Medicare-only counterparts (9 percent and 6 percent, respectively).[23] Overall, people of color represented 51 percent of dually eligible enrollees but only 20 percent of Medicare-only enrollees.[24] Targeting efforts to improve quality of care for the dually eligible population, therefore, holds promise to substantially reduce health care disparities. The GSCA will help health plans, systems, and providers make progress toward improving health equity by meaningfully engaging with older dually eligible adults and employing the core features of person-centeredness and geriatric competency.

Supporting Geriatric-Competent Care with the GSCA

The GSCA's Target Audience

The GSCA's audience includes health plans, systems, and providers—particularly those working with dually eligible older individuals—that wish to either begin or advance efforts to improve their geriatric competence.

Putting the GSCA into Context: Frameworks and Assessments

Several key frameworks informed the GSCA goals and organization. Of note, the John A. Hartford Foundation and the Institute for Healthcare Improvement's (IHI) [4Ms Framework of an Age-Friendly Health System](#) offers core goals and structure to the GSCA.[25] Each of the 4Ms identifies core elements of high-quality care for older adults and focuses on strengths and wellness rather than illness.

The 4Ms of an Age-Friendly Health System

What Matters: Understanding each individual's health goals and care preferences across settings to understand and align care

Medication: Using age-friendly medications that do not interfere with What Matters, Mentation, or Mobility

Mentation: Preventing, identifying, treating, and managing dementia, depression, and delirium across care settings

Mobility: Ensuring that older adults move safely every day to maintain function and do What Matters to them

Source: John A. Hartford Foundation [*Blog Post*](#)

B. Roadmap for Using the GSCA

Structural Overview

Both the GSCA User Guide and Tool follow the same four-domain structure (see Exhibit 1).

Exhibit 1: The Four Domains of the GSCA User Guide and Tool

Domain 1: Person-Centered Approach	**Understand your organization's progress toward person-centered care,** which recognizes that the individual is the primary source for defining care goals and needs, not merely a passive recipient of all care and supports.
Domain 2: Interdisciplinary Care Team Capacity and Organization Infrastructure	**Assess your organization's infrastructure and capacity** in these areas. • Interdisciplinary care team (IDT) capacity and coordination • Care availability • Facility, communication, equipment, and physical availability • Primary care capacity • Preventive care • Insurance coverage, incentives, and value-adds • Benefits, services, and programs available to dually eligible individuals • Financial and environmental support • Ombudsman • Health Insurance Portability and Accountability Act (HIPAA) compliance
Domain 3: Care Management and Care Planning	**Assess your organization's care management and planning** across several key areas, including oversight, coordination, medication, and care transitions.
Domain 4: Referrals and Community Engagement	**Assess your organization's processes pertaining to referrals** and supporting an individual's access to community-based services.

Domain-Specific Considerations for Practices Serving Dually Eligible Older Adults Each domain section begins with a callout box containing domain-specific questions to help your organization assess opportunities to improve interactions with dually eligible older adults.

How to Use This User Guide and Tool

RIC recommends that organizations' leadership support internal efforts to assess their readiness and commitment to providing evidence-based geriatric-competent care and that users reflect on all key functional areas within the organization while completing this assessment.

Completing the full GSCA Tool provides a holistic view of an organization's current state. However, a domain-by-domain review can establish domain-specific benchmarks and identify gaps it can fill with targeted QI efforts.

On assessment completion, RIC recommends that users debrief with relevant interested parties to identify strengths, weaknesses, action items, and achievable goals. Users might wish to discuss successes as well as barriers the organization overcame to achieve them. When devising subsequent action plans, users also might wish to leverage resources in the Appendix to further support future QI initiatives.

The remainder of this GSCA User Guide offers domain-specific (and subdomain-specific) background and context that explains the relevance of the associated questions. These domains and subdomains, outlined below, correspond to questions in the GSCA Tool. Users can rely on the GSCA Tool to capture responses and notes.

Domain 1: Person-Centered Approach

Domain 1 focuses on how understanding the individual as a whole person, respectful communication and collaboration, interprofessional teamwork, cultural awareness, and the individual's preferences for receiving their services can support mutually trusting relationships between care professionals and the individuals in their care.[26,27] Person-centered care requires personalizing all interactions with the individual to address their specific care needs and situation rather than presumed needs based on their demographic profile. Doing so requires tailoring all communications to the person's health literacy, language preferences, and physical and cognitive ability. Domain 1 and the associated questions in the GSCA Tool discuss person-centeredness as it relates to care assessments, individual-centered practice, advance care planning, eliminating medical and institutional bias, personal assistance, provider conduct, appropriate prescribing, and caregiving.

Quick Guide Step-by-Step Instructions for Using the GSCA

1. Download the GSCA User Guide (PDF file) and GSCA Tool (Excel file).
2. Review Part A of the User Guide for background on geriatric-competent care.
3. Decide whether you will focus on all or selected domains. Review the information in Part B of the User Guide to provide context for each domain of interest before answering the questions.
4. Open the GSCA Tool (Excel file) and complete the assessment with your team. As you consider each question, refer to the corresponding section in Part B of the User Guide Record.
5. Record your answers in the Excel file, which will automatically score your assessment.
6. Review your score, taking time to celebrate areas of strength or analyze areas that require additional support. Use these results to inform discussions with your team about setting goals and prioritizing action steps. Refer to the corresponding sections of the GSCA User Guide, as well as the domain-specific resources in the Appendix for ideas and additional guidance.

Domain 1 Considerations for Organizations Serving Dually Eligible Older Adults

- Given that dually eligible individuals are more likely to have complex care needs and be adversely affected by social determinants of health (SDOH), what steps do you have in place to provide person-centered and geriatric-competent care coordination?
- Can you identify instances when implicit bias might have been a factor for the IDT in developing care plans? If yes, what opportunities can you identify to support efforts to reduce biases? If no, can you articulate steps you have taken to increase staff awareness of health equity implications that your organization could replicate in other processes?
- Are your organization's leadership, providers, and staff aware of specific challenges affecting dually eligible older adults? Does your organization have protocols in place to ensure it prioritizes those needs?

1.1 Assessment

The GSCA questions within this subdomain help organizations evaluate their readiness to perform the initial assessment for older adults.

Pre-Assessment Screening for Older Adults. Organizations might want to consider performing a rapid screening assessment with older adults before any clinical evaluations to identify concerns regarding any of the following 12 areas—which in turn could trigger a more thorough assessment:

1. Mobility, falls with injury or facture, and fall risk (e.g., leveraging timed "get up and go" tests, life-space assessment protocols[28])
2. Nutrition (e.g., examining unintentional weight loss in the prior 6 months)
3. Vision (e.g., testing if the individual is unable to read a newspaper headline while wearing corrective lenses)
4. Hearing (e.g., measuring self-reported hearing loss or failure to pass a two-foot "whisper test")[29]
5. Cognitive function (e.g., testing three item recall after one minute, the Mini-Cog©)[30]
6. Depression (e.g., Geriatric Depression Scale)[31]
7. Anxiety (e.g., Geriatric Anxiety Scale)[32]
8. Frailty (e.g., FRAIL Scale)[33]
9. Caregiver availability, adequacy, and degree of strain
10. Use of a patient activation measure assessment[34]
11. Number of medications, side effects, accessibility, affordability
12. Hospitalizations in the last 6–12 months, emergency department (ED) visits in the last 6 months, and skilled nursing facility (SNF) stays in the last 12 months.

> **Principles of Geriatric Assessments**
> - *Goal*: Promoting wellness and independence
> - *Focus*: Function, performance (gait, balance, transfers), independence, and tradeoffs
> - *Scope*: Physical, cognitive, psychological, and social domains
> - *Approach*: Multidisciplinary
> - *Efficiency*: Ability to perform rapid screens to identify target areas
> - *Success*: Maintaining or improving quality of life

If the individual experiences a significant change in status, organizations might consider conducting a full or partial reassessment between regularly scheduled assessments. Functional status includes both activities of daily living (ADL)—walking, bathing, dressing, eating, toileting—and instrumental activities of daily living (IADL)—shopping, meal preparation, care of others. In addition to asking the older adult about health care incidents in the last year, organizations should check the patient's electronic health record (EHR), if available, and claims data to verify timelines.

Team members may wish to focus on screening for conditions common—but frequently underdiagnosed—in older adults (e.g., osteoporosis, behavioral changes, alcoholism, sexual dysfunction, macular degeneration, stroke, cognitive decline, Parkinson's disease).[35,36,37,38] Questions about social support, financial concerns, environment and living situation, care goals, advance care planning preferences, and long-term services and supports (LTSS) preferences are also parts of a geriatric-competent assessment. Individuals with

> **Potential challenges that affect care delivery related to aging include**
> - Modified, nonspecific, or atypical presentations of illness;
> - A variety of problems with multiple likely causes (e.g., geriatric syndromes such as falls, sleep difficulties, frailty);
> - Prescribing, overprescribing, or diagnostic errors;
> - Prolonged recovery from illness; and
> - Safety features of the individual's home environment (e.g., level of caregiver training; presence of stairs, rugs, clutter, handrails, grab bars; adequate access to nutrition).

multiple challenges from this list might benefit from a referral to a geriatrician, geriatric advanced practice nurse, or geriatric team for more comprehensive assessment and planning.

Adjusting Assessments for Older Adult Populations. Geriatric-competent organizations are aware of challenges that affect care delivery to aging individuals. They evaluate assessments, screening tools, and protocols to determine if such instruments are appropriate for an older adult clientele and when necessary, they adjust care assessments to ensure relevance to the target population.[39] Person-centeredness and geriatric competence require including individuals in the clinical assessment and engaging with them to help articulate their goals, values, and preferences.

Conducting Assessments with Older Adults. Completing the assessment in person can help establish a trusting and respectful relationship. Meeting in the older adult's living environment, when possible, can eliminate transportation or functional limitation-related access barriers for the older individual and their circle of support. This also affords opportunities to observe the individual's level of function within the home environment and suggest strategies to increase independence and safety in daily functioning.[40]

Agreeing Whom to Include in the Assessments. Geriatric-competent interdisciplinary care teams (IDTs) participating in an individual's assessment are sensitive to potential health concerns that, for some, have associated stigmas (e.g., depression, incontinence, change in sexual function, memory loss, falls). They also know that older adults might wish to include others (e.g., family members, caregivers, community supports) in the assessment. The individual's IDT should also actively participate by bringing their skills and perspectives to the discussion. Additionally, the IDT may wish to incorporate the expertise of other clinicians or care providers as identified and desired by the older adult.

> **When working with an older adult**, take the time to introduce yourself, sit at eye level, face the person, and speak slowly. Pace conversations about care decisions so the older adult, any family or caregivers, and the clinician all have time to evaluate options before proceeding. Use this opportunity to gain insight about the individual by actively engaging and partnering with them in the assessment process because participatory assessments often yield greater insights.

Finally, organizations with geriatric competence might have occupational, physical, and speech therapists perform home and community-based functional assessments as well as individual education. Organizations can refer individuals to home modification services offered by occupational therapists or certified aging-in-place specialists.[41]

Adhering to Current Policy in Written Communications. To properly serve the older adult population, organizations will want to ensure that all intake forms and other written communications adhere to the most current policy requirements under Medicare and Medicaid.

Section	1.1 Assessment: GSCA Question Text
1.1.1	Does your organization conduct its initial member assessment in person?
1.1.2	Does your organization conduct at least a portion of the initial assessment and the periodic reassessments in the individual's living environment?
1.1.3	Do all the core IDT members attend the individual's initial and subsequent assessments, whether in person or virtually?
1.1.4	Do you invite the individual to include family members, caregivers, or someone else whom they identify in the assessment process?
1.1.5	Do you identify additional expertise necessary to meet the individual's care needs?
1.1.6	Is the initial assessment (and the pre-assessment screening, if applicable) comprehensive and multidimensional, incorporating all aspects of the individual's life?
1.1.7	Are all assessment materials accessible and appropriate for older adults of all educational levels?

Section	1.1 Assessment: GSCA Question Text
1.1.8	Are assessment tools and forms accessible to older adults with visual impairment?
1.1.9	Are translated materials available and adequate?
1.1.10	Are the assessment measures culturally appropriate for your population?
1.1.11	Does the assessment identify services or equipment to maximize the person's independence?

1.2 Individual Centered Practice

Subdomain 1.2 assesses organizational readiness to begin the care planning process, engaging with older adults new to your organization, before any initial assessment. It also explores the concept of "dignity of risk," which calls on health professionals to respect the individual's choices—even when those are inconsistent with IDT recommendations.[42] Geriatric-competent providers consciously evaluate interventions and clinical recommendations against their effects on quality of life (as defined by the older adult) and tradeoffs, as well as any impact on independence.

Getting Started. A preliminary meeting can help establish the relationship with the individual, easing the way for a productive subsequent session focused on the assessment itself. To guide discussions, providers might wish to consult existing resources, such as the 4Ms Framework of an Age-Friendly Health System.[43] Organizations will want to explore, use, and recommend to individuals publicly available and evidence-driven resources to support individual-to-provider conversations. For example, developing a trusting relationship with the individual might be easier with an initial face-to-face interaction that includes discussion of the individual's goals, values, and preferences for their care and support. The Administration for Community Living (ACL) offers cultural competence resources to help providers elicit and echo the individual's values into clinical encounters.[44]

Preparing for Care Planning. An older adult's choices, preferences, and goals provide a foundation for their individualized and person-centered care plan. As described further in Subdomain 3.1, the care plan identifies all the care, services, and supports for each individual. It is a living document that the care team and individual review and revise to address evolving needs. Geriatric-competent organizations train staff to be sensitive to the individual's concerns and level of engagement. Organizations might also want to gauge the older adult's knowledge, skills, and confidence needed to fully engage in their treatment, which can include considering patient activation factors in the initial and subsequent assessments.[46]

> **Including Health and Wellness Elements into the Care Plan**
>
> When devising a person-centered care plan, organizations may wish to include elements of a health and wellness plan, such as
>
> 1. **Healthy lifestyle tips** (e.g., activity, nutrition, psychosocial health promotion, health practices)
> 2. **Resources** for accessing primary care
> 3. **Routine health prevention** services
> 4. **Chronic disease self-management practices** for any condition that limits function or quality of life
> 5. **Resources on preventing secondary disability** or complications
> 6. **Safety** and emergency plans
> 7. **Medication management** resources to ensure supply; outlining next steps should the individual miss a dose or experience an adverse drug reaction
> 8. **Caregiver backup plan** (as applicable) for when a caregiver is unavailable[45]

Pain, depression, anxiety, acute illness, or hearing loss might impede an older adult's ability to self-advocate or participate in decision-making. With the older adult's consent, organizations might involve families or caregivers more closely in the care planning process when providing care to individuals with those or other conditions, such as Alzheimer's disease and related dementias (ADRD) or individuals with intellectual and developmental

disabilities. Family members and caregivers might help relay symptoms to the care team and support appropriate follow-up with health professionals or community resources.[47]

Section	1.2 Individual Centered Practice: GSCA Question Text
1.2.1	Do individuals play an active role in their own assessment and care planning?
1.2.2	Do staff develop a relationship with the individual, showing respect for the older adult's preferences and for the dignity of risk?
1.2.3	Are older adults (and their families or caregivers) involved in care planning and implementation to ensure a person-centered focus?
1.2.4	Do staff consistently respect and accept the decisions and preferences of older adults?
1.2.5	Does the IDT periodically assess how well the individual understands their rights and protections?
1.2.6	Can individuals, caregivers, or personal care assistants (PCAs) access health promotion information specific to the individual?
1.2.7	Can individuals maintain existing relationships with LTSS providers?
1.2.8	Does the care plan integrate health and wellness plan elements?

1.3 Advance Care Planning

Subdomain 1.3 asks organizations to consider their readiness to support older adults in creating and implementing an advance care plan (ACP). Advance care planning is an interactive process between the older adult and their IDT to make decisions about end-of-life care issues, such as do-not-resuscitate orders, plans for palliative or hospice care, ventilator use, and artificial nutrition or hydration. Recent studies highlight the importance of ACPs for improving end-of-life outcomes.[48] These conversations can increase compliance with the individual's end-of-life wishes.[49]

> **IDTs can consider these recommendations to identify an individual's decisions and preferences.**
> - Seek to understand the individual's perspective, especially if they struggle to identify or assert preferences.
> - Respect the individual's preference even if it is inconsistent with the IDT's recommendation.
> - Discuss pros and cons of the individual's preference while advocating for recommended options.
> - Offer support if the individual is ambivalent or requests guidance.
> - Engage the individual and close family members or caregivers at all stages of the care process to effectively meet the individual's needs consistent with their preferences. This approach is particularly important for individuals with certain conditions who might have difficulty understanding information about their care.

Identifying a health care proxy is an important component to advance care planning. This individual helps voice the older adult's wishes should they lose their capacity to make decisions. Geriatric-competent care requires that the IDT discuss end-of-life care issues with respect and sensitivity.[50] For individuals with cognitive impairment, memory loss might affect their ability to participate meaningfully in decision-making, rendering early advance care planning even more important.[51]

Geriatric-competent organizations will want to ensure individuals have guidance (potentially from a member of the IDT) in completing ACP instructions. Organizations such as the National Institute on Aging (NIA) and IHI offer person-centered resources for providers to share with individuals to facilitate conversations regarding advance care planning (see the Appendix, below). Triggers embedded in the individual's care plan might serve as helpful reminders for the IDT to engage individuals in advance care planning discussions annually or after a significant change in health status.

Section	1.3 Advance Care Planning: GSCA Question Text
1.3.1	Do your providers routinely ask individuals to consider advance care planning?
1.3.2	Do your providers offer individuals counseling or assistance in advance care planning?
1.3.3	Do your organization's IDTs review all ACPs?
1.3.4	Do your organization's IDTs revisit ACPs at least annually with each older adult or after a significant change in health status?
1.3.5	Do providers assess and discuss end-of-life preferences with individuals and their families?

1.4 Eliminating Medical and Institutional Bias

Subdomain 1.4 helps organizations consider how to address persisting medical and institutional biases that might interfere with addressing the individual's choices, unique abilities, limitations, and preferences for social and community participation. The United States has a longstanding and historic structural bias favoring institutional care for older adults with a need for LTSS.[52] Research suggests that this bias has been slower to recede for older adults,[53] particularly within communities of color—which remain overrepresented in institutionalized settings.[54,55]

Many older adults prefer to remain at home and receive community-based supports rather than move into nursing facilities. Older individuals should have a range of options to meet their needs, including community supports and service providers. Geriatric-competent organizations recognize the factors that led to a bias toward institutionalization and evaluate each older adult's ability to remain in the least restrictive environment of their choice. Additionally, geriatric-competent organizations recognize the legacy of racial and ethnic disparities in care settings, implement formal protections to identify and eliminate bias toward institutionalization, and combat both implicit and explicit biases that lead to disparities in health and health care for older adults of color.[56]

Section	1.4 Eliminating Medical and Institutional Bias: GSCA Question Text
1.4.1	Does the IDT help individuals explore all possible options for living in the least restrictive environment of the individual's choice?
1.4.2	Does your organization conduct ongoing inventory scans of all available community supports and service providers in the area that they can share with the individual?
1.4.3	Does your organization reevaluate the individual's current living situation before planning a permanent transition to a greater level of care?
1.4.4	Does your organization formally review potential ethical conflicts to ensure the individual's autonomy and self-determination?
1.4.5	Does your organization provide general training on and assess staff knowledge of age-friendly or geriatric-competent care?
1.4.6	Does your organization offer specific staff training on cultural competence or implicit bias?

1.5 Personal Care Assistance

Subdomain 1.5 examines access to a variety of service delivery options related to personal care assistants (PCAs) as well as the role of IDT staff in supporting decision-making and backup care plans.

Older adults who require support performing ADLs or IADLs might wish to engage with PCAs to provide services and supports within their own home. Individuals can hire PCAs through a traditional agency or might employ them directly under the self-directed service model. The latter is helpful for individuals living in rural areas, which might have fewer available agency providers. The self-directed service delivery model empowers the individual to manage all aspects of their own services.[57]

IDT staff can support older adults by routinely reviewing options and sharing health care information with caregivers or confirming that the individual has a backup plan in place should their primary approach for caregiving fall through.

Section	1.5 Personal Care Assistance: GSCA Question Text
1.5.1	Does your organization give individuals a choice between an agency model and a self-directed model for their PCAs?
1.5.2	Are individuals able to maintain access to existing or preferred PCAs?
1.5.3	Do IDT staff regularly consult individuals about their options to share protected health information (PHI) with caregivers?
1.5.4	Are staff aware of an older adult's backup plan to provide replacement caregiving in case of an emergency? Does staff know about resources they may leverage to assist the individual, if needed?

1.6 Provider Conduct

Subdomain 1.6 assesses clinical interactions that help care providers establish the older adult's trust. When the older adult has a family caregiver, providers can glean important insights from conducting a family assessment. Providers should use a cultural competence lens when determining the family caregiver's abilities, needs, wellbeing, and goals in their caregiving responsibilities. Such assessments can help bring to light important elements (e.g., relevant family dynamics, social risk factors) that can inform the provider's care plan recommendations.[58] Bringing cultural and linguistic competence into discussions about physical exams, family assessment, end-of-life care, and other needed services can also support a robust dialogue between an older adult and their provider.

In addition to verbal communication, geriatric-competent organizations understand the importance of nonverbal communication as a tool that can help providers connect with the older adult and reinforce understanding and respect (e.g., nodding and showing interest in what the individual is saying, making eye contact, sitting at eye level, avoiding typing in the EHR when speaking).[59]

Section	1.6 Provider Conduct: GSCA Question Text
1.6.1	Does your organization ensure that providers receive training in how to conduct geriatric cross-cultural interactions?
1.6.2	Do providers strive to gain the trust of the older adult?
1.6.3	Do providers use respectful and appropriate nonverbal communication?
1.6.4	Do providers conduct family assessments?
1.6.5	Are providers sensitive to cultural differences when conducting physical exams?

1.7 Appropriate Prescribing

Subdomain 1.7 evaluates provider precautions to avoid inappropriate medication and prescribing practices. Research shows that the likelihood of an adverse drug event (ADE) rises as the number of prescribed medications increases—and that 40 percent of individuals age 65 and older are taking more than five medications (i.e., polypharmacy).[60] Moreover, 65 percent of dually eligible individuals have two or more chronic conditions and, therefore, tend to use multiple medications and have higher Medicare Part D prescription drug costs than Medicare-only beneficiaries.[61,62] Older adults also are significantly more likely than their younger counterparts to experience ADE-related hospitalizations.[63] Problematic polypharmacy also occurs when clinicians misinterpret an ADE as a new medical condition and prescribe additional drug therapy to treat it, and that prescribing cascades.[64]

This subdomain addresses a holistic consideration of the individual's health status before ordering prescriptions. It also discusses adherence to the Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults—a widely-used tool stewarded by the American Geriatrics Society to educate both clinicians and those in their care about medication selection.[65]

Section	1.7 Appropriate Prescribing: GSCA Question Text
1.7.1	Do providers consider age-related body changes and comorbidities when prescribing?
1.7.2	Do providers take necessary precautions to avoid ADEs?
1.7.3	Are providers familiar with the most current Beers Criteria for Potentially Inappropriate Medication Use in Older Adults?

1.8 Caregiving

Subdomain 1.8 discusses caregivers, or the individuals responsible for attending to the daily needs of another person who is unable to manage themselves independently.[66] Paid caregivers include home and community-based workers compensated for their services. Unpaid caregivers, often labeled "informal caregivers" or "natural supports," might include family members, partners, friends, neighbors, members of community and civic organizations, or others.[67]

Caregivers provide physical and emotional support to individuals requiring assistance with ADLs and IADLs and are vital to keeping older individuals in the least restrictive setting. As people age, their need for such assistance increases. Adult children might provide support, but increased life expectancy and changing norms around family demographics—such as grown children living far from their parents—often require alternative care delivery arrangements.

Frequently, caregivers are older adults themselves, supporting a spouse, sibling, friend (who also might be an older person), an adult child, or even a grandchild. Informal caregivers frequently have little, if any, external support. Geriatric-competent organizations will want to understand the natural supports available to an individual as well as any caregiving responsibilities the individual has for others.

Given the impact that caregiving can have on an older adult's wellbeing, understanding any caregiver dynamic is critical to empower IDT staff to provide appropriate care and information on respite and other supports. For example, the Eldercare Locator offers resources from NIA, the Family Caregiver Alliance, the Dementia Action Alliance, and local community supports.[68] To promote awareness of the older adult's caregiving situation, staff can note details within the individual's care plan itself and can document parameters for communication between the IDT and the caregiver. Staff also must be aware of privacy rules related to HIPAA.[69] The IDT might provide informal or formal training to caregivers, as well, on topics such as ADL assistance, specific diseases, emergency management, or signs of elder mistreatment and exploitation. Privacy considerations are covered in greater depth in Subsection 2.11.

> **Older adults might need informal short-term or longer-term caregiving for an indefinite period. Such natural supports might assist with**
>
> - ADLs (e.g., walking, bathing, dressing, eating, toileting);
> - IADLs (e.g., shopping, food preparation, housekeeping, laundry, telephone or computer use);
> - Monitoring symptoms and administering medication;
> - Emotional and social support;
> - Finding and accessing services (e.g., housing, medical supports);
> - Behavioral support, such as recognizing and responding to behavioral expressions in persons living with dementia (e.g., wandering, aggression, hallucinations); and
> - Finances (e.g., managing bills, direct financial support).

An older adult's caregiver, who might accompany the individual to medical appointments and can help the individual follow the agreed plan of care, is a valuable source of information for providers. If appropriate, as your organization completes this assessment, also consider that informal caregivers of older adults located in rural areas face a unique set of challenges,[70] including:

- Geographic isolation;
- Difficulty accessing formal health care and social services;
- Lower median income and more financial hardship than urban areas; and
- Greater needs for long-term care (LTC).

Caregivers in rural communities might have less access to formal support services, such as support groups, aid or nursing agencies, or other assistive paid caregiving services.[71] Organizations will want to consider the needs of rural caregivers when coordinating respite care or otherwise connecting them to support or educational services that can help them in providing care to older adults.[72]

Section	1.8 Caregiving: GSCA Assessment Question Text
1.8.1	Do IDT staff ask the individual about their role as caregivers to geriatric partners, family members, friends, or neighbors?
1.8.2	Can IDT staff assess how caregiving affects an older adults' physical, emotional, and financial status?
1.8.3	Are IDT staff aware of older adults in their care who have custody of children?
1.8.4	Are IDT staff aware of resources available to grandparent caregivers?
1.8.5	Are IDT staff aware of the individual's informal caregiving needs?
1.8.6	Does the IDT routinely ask whether individuals have an ongoing caregiver who accompanies the individual to medical appointments and, relatedly, does the IDT recommend involving a caregiver escort when it deems such an escort necessary?
1.8.7	Has the IDT established a means of communication between the IDT and the identified caregiver?
1.8.8	Does the IDT offer caregivers information or training to support their role?
1.8.9	Does the IDT regularly ask caregivers to complete a caregiver assessment (e.g., Zarit Burden Interview)?[73]
1.8.10	Are staff aware of respite care available for individuals' informal caregivers and, relatedly, do they share such information with the individual or caregiver?
1.8.11	Does your patient population exhibit traits (e.g., rurality) that inform how you support caregivers?

Domain 2: Interdisciplinary Care Team Capacity and Organization Infrastructure

Domain 2 focuses on IDT capacity, their ability to use health equity considerations to inform strategic decision-making, and the organization's infrastructure, all of which are critical to delivering geriatric-competent care.[74] Questions in this domain of the GSCA Tool measure organizational primary care capacity, clinic accessibility, and providers' fluency with safe prescribing techniques.

> **Domain 2 Considerations for Organizations Serving Dually Eligible Older Adults**
> - Is the organization aware of which community wellness services are covered benefits for dually eligible populations? Do they exclusively refer dually eligible individuals for covered benefits?
> - Can your organization segment clinical data for dually eligible individuals (versus those enrolled only in Medicare)? If so, would you consider comparing processes and outcomes to identify opportunities for process improvements that might improve care for dually eligible enrollees?
> - Do you make resources available to staff about in-network specialty providers that accept dually eligible individuals? Does your organization have protocols in place for warm handoffs to support dually eligible individuals through the care transition process?
> - Are care coordinators well versed in the financing options and additional funding sources available to dually eligible individuals?

2.1 Interdisciplinary Care Team Capacity

Subdomain 2.1 assesses the organization's IDT capacity. Geriatric-competent IDT-based care includes core competencies in primary care, behavioral health, geriatrics, and LTSS. Operating in close communication with the individual and external providers, the IDT must understand each team member's individual roles and responsibilities as well as available community- and facility-based LTSS. The IDT should also know about community-based resources (e.g., equipment rentals) to support the individual's health and wellbeing and prevent avoidable episodes or illness progression. Organizations will want to empower the IDT to take responsibility for ensuring that the individual receives the care and supports they need to achieve their goals and maximize independence. LTSS—whether in the home, a community-based setting, or a facility—enables older adults with disabilities to live more independently and participate in the community, thereby improving quality of life and functioning.[75,76] Organizations might conduct LTSS assessments with individuals to identify their functional capabilities and prioritize resource allocation. Completing such assessments commonly requires the organization to invest in resources to support the individual's health and wellbeing, which, in turn, might prevent avoidable episodes of illness or illness progression.[77]

Competencies in the IDT. Because no one professional has all the training required to assess an individual holistically, when possible, organizations serving older adults might wish to employ IDTs. Such organizations might also choose to engage in staff training programs focused on aging and disability sensitivity and awareness, including core concepts of gerontological practice and the Independent Living model.[78,79] To communicate with individuals who have expressive or receptive communication challenges, the team might consider leveraging assistive technologies. IDTs should include staff with competencies in primary care, nursing, behavioral health, and both community- and facility-based LTSS. Because specialized training is essential for effective assessment and care, one or more IDT members should have geriatric or gerontology credentials. Some organizations choose to assign the team lead to a specific role—for example, the primary care practitioner (PCP)—although other organizations might use a collaborative practice model or choose to vary the team lead designation based on the individual's unique needs or preferences.

Telemedicine offers significant promise to support IDT capacity, but also comes with its own access barriers, including insufficient computer literacy among some older adults and inconsistent internet bandwidth to support its use in rural areas. Geriatric-competent organizations should work to capitalize on the opportunities posed by telemedicine technology while also recognizing its limitations.

Cultural Competence and Language Barriers. Cultural and linguistic competence are core elements for any person-centered, geriatric-competent IDT. Providers might wish to conduct ethnogeriatric

assessments before a medical exam to ensure they have sufficient context about an individual's characteristics that might affect the care plan (e.g., ethnicity, religion, sexual orientation, primary language, communication behaviors, home environment).[80]

In addition, language barriers can present an obstacle to effective relationships between IDTs and the individuals they serve. Geriatric-competent organizations work with interpreters trained in person-centered principles and provide materials in languages other than English. Although some situations might require relying on family members as interpreters, doing so can inadvertently introduce communication risks (e.g., potential conflicts of interest, limited language skills to facilitate interpretation, culturally based barriers). Geriatricians should maintain a list of available onsite and telephonic interpreters.

Section	2.1 Interdisciplinary Care Team Capacity: GSCA Question Text
2.1.1	Does each IDT include providers of primary care, nursing, behavioral health, geriatrics, and social work?
2.1.2	Are IDT members experienced in providing disability-competent care?
2.1.3	Does your organization consider the individual's primary language, means of communicating, and ethnic or cultural competencies when it identifies and assigns specific members of the IDT?
2.1.4	Do all IDT members understand their individual roles and responsibilities?
2.1.5	Does your organization ensure that one member of each IDT is designated as the "lead?"
2.1.6	Are IDT staff trained to watch for and report concerning relationships at the older adult's place of residence, such as abuse, neglect, and exploitation?
2.1.7	Are IDT staff trained to watch for and report concerning caregiver relationships, such as abuse, neglect, and exploitation?
2.1.8	Can providers select an appropriate interpreter, if necessary?
2.1.9	Are providers capable of conducting an ethnogeriatric assessment?
2.1.10	Do providers conduct home assessments?
2.1.11	Does your organization have adequate capacity to continuously evaluate staff needs and then train and educate staff accordingly?

2.2 Interdisciplinary Care Team Coordination

Subdomain 2.2 assesses the efficiency of IDT communication and coordination and identifies opportunities to improve coordination.

Many organizations use structured agendas to facilitate recurring in-person or virtual IDT meetings. Person-centered and geriatric-competent organizations also review care plans at regular intervals (biannually, at a minimum) as well as whenever new conditions emerge or existing conditions worsen. Geriatric-competent organizations empower IDTs to alter the scope, intensity, and frequency of not just care delivery, but also supports and services. Additionally, organizations might enable IDT members to maintain flexible schedules, giving them flexibility to address emergent changes.

The IDT should derive specific services and supports listed in the care plan from the assessments, which the IDT should review and update periodically to help ensure that it continues to reflect the individual's preferences and needs to achieve their goals. At a minimum, information included in each individual's care plan should be available to the IDT via fax or encrypted in secure email but ideally in the form of a remotely accessible EHR.[81] Should an individual specify a family member or other person to be involved in IDT communications, age-friendly organizations must document that information in the care plan and communicate it to all IDT members to ensure consistent follow-through. If the individual's health plan requires preauthorization, the organization should share the plan's approval criteria with both the individual and their IDT to promote transparency.

> **IDTs can consider having system triggers in place to ensure timely coordination of care, including**
> - Review of any individual under acute care;
> - Review of any individual transitioning from one facility to another care setting, whether another facility or community residence;
> - Discussion of a change in health or caregiver status;
> - Routine, scheduled case reviews; and
> - Annual advance care planning discussions, or more frequently if a significant change in health status occurs.

Section	2.2 Interdisciplinary Care Team Coordination: GSCA Question Text
2.2.1	Does the IDT meet weekly to discuss relevant individual updates, new assessments, and reassessment reviews?
2.2.2	Does the IDT ensure that each individual's care plan is reviewed at predetermined intervals?
2.2.3	If an individual maintains a relationship with an external care provider (i.e., a provider outside the IDT), is a staff member designated as the point of contact for the external provider?
2.2.4	Is the IDT able to meet, either in person or virtually, within 24-48 hours if the individual's needs or situation changes?
2.2.5	Is the assessment and care plan available to those providing after-hours coverage?
2.2.6	Are traditional services or supports substituted with alternative services that might not be considered "covered services," when appropriate?
2.2.7	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)?
2.2.8	Are staff trained in facilitating ACP and end-of-life care discussions?
2.2.9	Are additional resources or consultants available to the IDT based on the specific needs of each individual?
2.2.10	Is the individual able to designate a family member or close friend to receive IDT-related communications?
2.2.11	Is the IDT aware of what informal needs are met through the older adult's natural supports and what formal services are provided by hired staff?

2.3 Care Availability

Subdomain 2.3 addresses issues related to care availability, which includes timeliness of primary care—often a key factor in reducing ED and inpatient use and costs. Some organizations opt to hire or contract with PCPs to provide coverage after hours or on standby. Providing direct care in the community or an individual's place of residence is often necessary because transportation can be difficult to arrange and is a barrier to accessing timely care. Some organizations opt to hire or contract with PCPs to make home visits and take calls as needed from older adults. Ongoing communication among members of the IDT is essential for optimal geriatric care and requires special attention when an individual routinely engages with community providers and medical specialists in addition to their IDT.

Aside from primary care, organizations serving older adults recognize that this population might need timely intervention to avoid complications and ED visits. Some practices might augment clinic-based PCP services by having nurse practitioners (NP) available for home visits or in-clinic consultations. Some geriatric-competent organizations contract with crisis intervention providers and peer-support workers who can respond to the needs of older adults with behavioral health conditions. This service can extend to providing home and community-based services (HCBS) and emergency accessible transportation.

Section	2.3 Availability of Care: GSCA Question Text
2.3.1	Are PCPs readily available for timely diagnosis and treatment?
2.3.2	Are PCPs available to provide care in the community (e.g., clinic, place of residence)?
2.3.3	Are PCPs' schedules sufficiently flexible to provide same-day episodic care?
2.3.4	Are intervention services for behavioral health crises available at all times?
2.3.5	If applicable, do nonprimary care entities routinely communicate with the IDT or primary care manager to ensure adherence to treatment plans and follow up on referrals?

2.4 Facility Communication, Equipment, and Physical Access

Subdomain 2.4 assesses provider awareness of accessibility and the physical environment of the offices serving older adults, which includes building entrances, parking facilities, hallways, waiting rooms, restrooms, elevators, and examination rooms (e.g., physically accessible to both manual and motorized wheelchair users). Clinical environments serving older adults should be free of distractions (e.g., loud music, clutter), offering an accessible, comfortable environment. Geriatric-competent primary care practices include wheelchair-accessible examination tables, scales, and lifts—as well as restrooms, waiting areas, and corridors. They also have available equipment to facilitate examinations (e.g., blood pressure cuffs in a variety of sizes). An accessible environment will include ample accessible parking spaces and automatic doors with wide doorways. When an office spans multiple levels, it should offer elevators, ramps, or lifts. Likewise, examination or treatment rooms should be near the waiting room to reduce walking distance.

> **To help ensure physical accessibility, it is helpful for care settings to have**
> - Parking for persons with disabilities, as well as a designated drop-off area;
> - Easy-to-use, sturdy chairs and wheelchairs in the lobby for individuals arriving by foot;
> - Accessible restrooms for persons with disabilities as well as a family restroom; and
> - Multiple chairs in the examination room to accommodate family members or caregivers.

Geriatric-competent organizations will also want to provide their staff with disability assistance training. For example, office and medical assistants know how to assist the individual when walking or moving onto an exam table, when necessary.

Communication can be difficult for older people, particularly those with hearing or cognitive impairments. For example, individuals with ADRD might have difficulty finding the right word or lose their train of thought when speaking. They might struggle to understand certain words, have trouble paying attention during long conversations, or express sensitivity to touch or to voice tone or volume. Geriatric-competent organizations facilitate communication with

- Amplification devices;
- In-office communication devices (e.g., staff mobile phones, paging systems, nurse call systems that allow individuals or caregivers to contact staff for help while waiting in exam rooms);
- Communications facilitators;
- Telemedicine for older adults without easy access to in-person visits or facilities;

- Foreign language translation;
- American Sign Language (ASL) and ASL interpreters;
- Teletypewriter (TTY)* and text support for mobile phone or Internet-based communication; and
- Home-based primary care visits for individuals with severe mobility challenges.[82]

If an older individual uses equipment in the home, such as lifts, arrangements should be made to have comparable equipment available at all other sites where the individual receives care. Understanding the needs of the individual ensures their safety when they are in a setting other than their own home.

Section	2.4 Facility Communication, Equipment, and Physical Access: GSCA Question Text
2.4.1	Are primary care practices and other settings arranged for accessibility, with minimal hazards, and as a pleasant, reassuring, age-friendly environment?
2.4.2	Do primary care practices and other care settings have adequate equipment (e.g., scales, exam tables, lift equipment) to provide comprehensive care for individuals with physical and cognitive impairments?
2.4.3	Are clinical environments accessible to older adults?
2.4.4	Are clinical environments comfortable for older adults?
2.4.5	Do individuals have access to the care and equipment they need to maximize health and independence, both in and outside the home?
2.4.6	Do all care settings offer communication access, such as translation of written materials or language interpretation of discussions?
2.4.7	Do organizations modify communications for individuals with cognitive impairments?
2.4.8	Are office staff, in addition to clinical staff, trained in providing physical assistance to older adults, when needed?

2.5 Primary Care Capacity

Subdomain 2.5 discusses infrastructure for geriatric-competent primary care services. Because PCPs (e.g., physicians, NPs, physician assistants) are often responsible for conducting screenings during annual visits (e.g., routine assessments for cognitive decline), they frequently diagnose changes in health and refer individuals to specialists and other community resources. For this reason, enhancing geriatric competence among PCPs can support older adults seeking health care services.

Person-centered and geriatric-competent care requires PCPs to tailor traditional protocols and practices for management of chronic conditions to meet each individual's unique profile—their range of health needs, medications, functional status, and available supports. For example, an individual with insulin dependent diabetes who is experiencing vision loss might need additional tools to conduct and read blood sugar tests. To effectively manage chronic conditions of dually eligible individuals, PCPs might consider leveraging telemedicine or remote monitoring options, when feasible, to facilitate access to preventive care and ensure continuity of care for individuals with multiple chronic diseases.[83]

When engaging with contracted primary care practices, geriatric-competent organizations frequently designate a lead geriatric practitioner or point person to provide ongoing oversight and coaching to the external practice and its practitioners. The organization can support at least some integration of behavioral health with primary care and LTSS.[84] Integration options might include colocation, which can

---

* TTY is a data terminal that converts incoming phone calls and voice responses into text. This device helps those with hearing impairments use the telephone.

facilitate primary care EHR access for behavioral health providers and LTSS care managers or PCP participation in IDT meetings.

Geriatric-competent organizations develop and share checklists, which identify structural elements that can help PCPs better accommodate older adults (e.g., ramps, wheelchair scales, accessible entry points) as well as guidance for staff on topics related to enhancing communication (e.g., telephonic communication for individuals with speech, visual, or hearing impairments). Organizations might also offer guidance on other geriatric-competent strategies, such as tips on proactive planning with older individuals, caregivers, care managers, transportation providers, and others. They also maintain an easily accessible list of preferred geriatric-capable subspecialists.

Virtual Care Options. Organizations also might consider implementing telemedicine to expand access to primary care services. Remote monitoring and care management is an important strategy to combat resource and staffing shortages to maintain care delivery. Virtual care options continue to increase the reach of health care providers and ensure quality of care and continuity of care,[85] but organizations should remain aware that such options may be unavailable to some older adults. Individuals living in rural areas that lack sufficient high-speed internet bandwidth might have limited access to technology-related supports for health information.

Ongoing Training and Education. Organizations serving older adults often offer training programs for staff, either with internal resources or by contracting with specialized educational trainers. Offering continuing education credits might increase provider engagement.

Possible Staff Training Topics

- Geriatric philosophy and approaches to care delivery
- Altered (and nonspecific) presentations of disease in older adults
- Invisible or "hidden" conditions (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., ADRD, intellectual and developmental disabilities)
- Comprehensive medication management (e.g., polypharmacy, flagging potentially inappropriate or high alert medications, documenting adverse drug reactions, identifying protocols for medication discontinuation)
- Functional assessment, frailty, and patterns of disability and habilitation
- Abuse or mistreatment
- Driving assessment, safety, and cessation
- Palliative care

Section	2.5 Primary Care Capacity: GSCA Question Text
2.5.1	Are strategies employed to broaden access to and the reach of PCPs?
2.5.2	Does your organization assess the geriatric capacity of provider networks?
2.5.3	What training does your organization offer to help PCPs enhance their geriatric awareness and competencies?
2.5.4	Do all primary care practices have a network of accessible geriatric-competent providers for basic diagnostic tests, including x-ray and laboratory testing?
2.5.5	Does your organization have strategies in place to support primary and behavioral health care integration—as well as collaboration among providers of primary, behavioral health, and LTSS care?
2.5.6	Do all PCPs have access to a network of medical subspecialists with experience caring for older adults?

Section	2.5 Primary Care Capacity: GSCA Question Text
2.5.7	Do PCPs use care guidelines to observe secondary complications of chronic conditions or common problems associated with aging?
2.5.8	Does your organization offer PCPs guidance on how to tailor care protocols and registries for older adults managing chronic conditions?
2.5.9	Do PCPs follow clinical protocols for identifying and treating key secondary conditions related to functional capacity in the older adult (e.g., bowel or bladder problems, fatigue, obesity, ulcers)?
2.5.10	Does your organization offer telemedicine or other virtual options to expand access to primary care?

2.6 Preventive Care

Subdomain 2.6 assesses the organization's capacity for preventive care. Preventive care is particularly important for dually eligible older adults, who disproportionately suffer from primary care–sensitive physical conditions. Optimal geriatric care focuses on preserving and maintaining health, optimizing function, and preventing avoidable complications. Providers should carefully consider whether recommended tests, treatments, immunizations, screenings, and medications are appropriate for the older adults in their care. Additionally, they should consider the individual's ability to tolerate lengthy procedures or testing when prioritizing preventive care activities.[86]

The Centers for Disease Control and Prevention recommends annual physical exams for adults age 65 and older.[87] Annual checkups enable organizations to monitor patients for immunizations and other critical preventive services. Organizations will want to include triggers in their EHRs to call and remind individuals to schedule wellness exams. Additionally, geriatric-competent providers proactively address safety issues common among older populations (e.g., fall prevention).[88]

Geriatric-competent providers are knowledgeable about common prescriptions, drug interactions, and over-the-counter medications related to prevention—such as low-dose aspirin or vitamin D supplements—and discuss these medications with older adults. Providers also might want to reference the U.S. Preventive Services Task Force (USPSTF), an independent group of national experts dedicated to improving Americans' health through evidence-based recommendations about clinical preventive services (e.g., screenings, counseling services, preventive medications).[89] The USPSTF issues prevention and screening recommendations for more than 80 health conditions and diseases.[90]

Section	2.6 Preventive Care: GSCA Question Text
2.6.1	Are providers familiar with the U.S. Preventive Services Task Force?
2.6.2	Do providers recommend annual physical or wellness exams that include regular screenings (e.g., osteoporosis, cancer)?
2.6.3	Do providers prescribe preventive over-the-counter medications, vitamins, or dietary supplements?
2.6.4	Do providers monitor immunization records?

2.7 Insurance Coverage

Subdomain 2.7 assesses the organizational knowledge of health insurance coverage. Health professionals caring for older individuals should have a foundational knowledge of Medicare and Medicaid eligibility requirements to help enhance care coordination activities.

National Coverage Determination (NCD) Process. Medicare covers services that are "reasonable and necessary for the treatment of an illness or injury" and within the scope of a current Medicare benefit category.[91] CMS has processes for both national and local Medicare coverage determinations. The

national process, which generally takes 9–12 months from the time CMS accepts an NCD request, results in a decision either to allow or disallow Medicare to pay for a specific health care service anywhere in the United States.[92] In the absence of the NCD, local coverage determinations are at the discretion of regional [Medicare Administrative Contractors](#).[93]

Medicare-Covered Preventive Services. Medicare will cover preventive care services that the USPSTF identifies as "Grade A" or "Grade B" recommendations with no out-of-pocket cost to the enrollee.[94,95] However, although Medicare Advantage (MA) plans might provide supplemental benefits, some evidence-based preventive services (e.g., screening for visual or auditory impairment) are not universally covered.[96] Medicare might cover additional preventive and screening services that CMS deems reasonable and necessary for the prevention or early detection of an illness or disability, but the criteria are stringent and the approval process can be lengthy.

Coverage for Dually Eligible Individuals. Dually eligible individuals are entitled to programs and services available under both Medicare (a federal program) and Medicaid (a joint federal and state program). Medicaid benefits vary greatly by state, in part because Medicaid agencies can apply for waivers that allow states to enhance services available to specific populations with federal dollars. Dually eligible individuals may also enroll in an MA plan—a managed care plan that often provides supplemental coverage and care coordination services. A Dual Eligible Special Needs Plan (D-SNP) is an MA plan designed exclusively for dually eligible individuals. Exact D-SNP eligibility requirements vary by state and D-SNP integration level. Geriatric-competent organizations are familiar with the range of health care services to which each dually eligible older adult in their care is entitled, as well as how those services are funded.

Identifying Resources Available to Medicaid Beneficiaries. Providers and others involved in the individual's care should offer personalized information about available resources to help older adults obtain information about Medicare, Medicaid, and community-based resources. Although clinicians need not be fluent in Medicare and Medicaid eligibility rules, they should be able to direct older individuals and their caregivers to experts for advice and resources (e.g., Aging and Disability Resource Centers [ADRCs], Area Agencies on Aging [AAAs], certified professional geriatric care managers, geriatric social workers).

Managed Care. Many states opt to deliver their Medicaid services and programs through state-contracted managed care organizations (MCOs). States regulate Medicaid MCOs, but federal law requires all MCOs to meet certain universal standards. MA (also known as Medicare Part C) gives beneficiaries the option of receiving their Medicare benefits through private health plans.

Incentives and Supplemental Benefits. MAPD plans and MCOs might provide additional benefits—above what enrollees would receive if they were not in managed care. These "supplemental benefits" might include dental coverage, access to weight loss or smoking cessation programs, prescription drug coverage, transportation for medical and nonmedical purposes, career development services, or vision care.[97,98] Geriatric-competent organizations might provide guidance to older adults about the range of managed care plan options from which the older enrollee might choose, as well as the value-added services each plan offers.

Section	2.7 Insurance Coverage: GSCA Question Text
2.7.1	Are providers aware of which preventive care services are covered under Medicare?
2.7.2	Are providers familiar with the national coverage determination process?
2.7.3	Does the IDT understand the concept of dual eligibility, as well as the characteristics of older adults within the dually eligible population?

Section	2.7 Insurance Coverage: GSCA Question Text
2.7.4	Are staff in your organization generally knowledgeable about the different types of Medicare delivery options (i.e., MAPDs vs. Medicare fee-for-service), and the various eligibility categories for dual Medicare-Medicaid enrollees in your state?
2.7.5	Do staff know to whom they should refer dually eligible individuals for explanations of their Medicare and Medicaid coverage?
2.7.6	Are staff in your organization generally knowledgeable of MAPD and Medicaid supplemental benefits available to older adults in your state?
2.7.7	Do the providers in your organization understand how to work with the MCO to facilitate optimal care and services for older adults?
2.7.8	Is the provider aware of incentives available from managed care companies for their members?

2.8 Pharmaceutical Assistance

Subdomain 2.8 assesses the organization's understanding of pharmaceutical assistance. Medicare and Medicaid might cover a portion of the costs, leaving dually eligible individuals responsible for the balance. When prescribing to dually eligible individuals, consider whether generic or less expensive options exist to minimize the treatment plan's associated out-of-pocket costs.

Federal Government Assistance Programs. Dually eligible individuals have Medicare Part D coverage for prescription drugs and automatically qualify for the Extra Help Medicare program, which covers additional costs (e.g., premiums, deductibles, coinsurance, possibly Medicare-excluded medications).[99]

State Government Assistance Programs. Some states have expanded their Medicaid coverage to provide additional prescription medication coverage. More information about a state's particular prescription drug coverage is available on your state's Medicaid website.[100]

Private Pharmaceutical Assistance Programs. Some pharmaceutical companies provide support, like copay assistance, insurance counseling, and free or discounted medicines to eligible individuals. Geriatricians familiar with such programs can help clients access and afford necessary medications.

Promising Practices to Reduce Pharmaceutical Costs. Geriatric-competent organizations recognize that optimizing nondrug therapies might reduce dosage requirements for some medications. Providers might wish to consult with pharmacists and compare costs and clinical outcomes for medications in the same therapeutic class.

Section	2.8 Pharmaceutical Assistance: GSCA Question Text
2.8.1	Do providers understand what pharmaceutical assistance is available under Medicare and Medicaid?
2.8.2	Do providers consider Medicare Part D drug coverage when developing treatment plans?
2.8.3	Do providers optimize therapeutic strategies that do not rely on pharmaceuticals?
2.8.4	Does the provider know of additional financial assistance from pharmaceutical companies?

2.9 Financial and Environmental Support for Ancillary Services

Subdomain 2.9 explores the IDT's knowledge of resources available to assist older adults with ancillary services that support their IADLs (e.g., nonmedical transportation, housing, utilities, nutritional needs, certain HCBS, or other services not covered by Medicare or Medicaid). Although Medicare and Medicaid pay for health-related expenses for dually eligible individuals, their financial needs expand beyond paying for health care services.

Although ancillary services are outside the health care realm, they impact older adults' overall wellbeing, safety, and health. A geriatric-competent organization can play a pivotal role in holistically supporting individuals by connecting them to additional resources.

> **The IDT can help older dually eligible individuals learn about tax breaks that help cover costs for ancillary services, such as**
> - Claiming the "Child and Dependent Care Credit" on federal income tax returns,
> - Using a workplace flexible spending account to fund out-of-pocket medical expenses and dependent care expenses with pretax dollars, and
> - Claiming additional state-specific tax deductions or credits that offer financial relief to caregivers.

Government-Funded Programs. Older adults living on low incomes might qualify for the Supplemental Nutritional Assistance Program, the Medicare Savings Program, or state cost-sharing programs. Veterans benefits and tax relief programs might also offer support.

Local Programs. Geriatric-competent social service professionals and care managers are aware of available local and regional charitable foundations that provide additional assistance. These resources might provide services such as housekeeping, grocery shopping, yard work, and other light maintenance tasks at their residence. Local AAAs or ADRCs, certified professional geriatric care managers, geriatric social workers, local faith-based organizations, and 2-1-1 can offer additional resources.[101]

Funding Supports for Aging in Place. HCBS, Medicare Part A, and the Medicare Home Health Care Benefit (Parts A and B) might pay for certain services that support aging in place. To sustainably fund such activities for individuals in rural areas, organizations might engage with partner organizations, grants, and contracts related to the Older Americans Act (e.g., those supported by the Health Resources & Services Administration [HRSA]). Additional funding programs, such as those listed under the Rural Health Information Hub's Rural Funding & Opportunities, provide financial support to organizations serving individuals in rural areas.

Funding Supports for Nutrition Services. Organizations that work with older adults can help ensure that staff are knowledgeable about food and nutrition resources for individuals with low or fixed incomes.

> **Examples of Nutrition Supports**
> - Commodity Supplemental Food Program
> - Senior Farmers Market Nutrition Program
> - Community-based organizations funded through government grants and private donations to provide congregate and home-delivered meals (e.g., Meals on Wheels, senior centers)
> - Food banks

Funding Supports for Transportation. Although only medical transportation services are covered by Medicare or Medicaid, safe and accessible transportation is critical to older adults' quality of life. Geriatric-competent health care professionals are knowledgeable about transportation resources, including AAAs, ARDCs, and other local contacts for free or low-cost senior transportation (e.g., local volunteer driver programs or discounted or free public transportation coupons).

Health plans, systems, and providers might wish to refer older adults to a social worker or care manager to assess the individual's unique situation and help identify additional opportunities to optimize financial supports for ancillary services.

Section	2.9 Financial and Environmental Support for Ancillary Services: GSCA Question Text
2.9.1	Is the IDT aware of resources or resource points of contact to assist individuals with transportation that is not medically related?
2.9.2	Is the IDT aware of resources and points of contact to assist older adults with housing and utilities?
2.9.3	Is the IDT aware of resources to assist individuals with meals or nutritional supplements?
2.9.4	Is the IDT aware of resources to assist older adults with other services, supports, and incidentals that are generally not covered by Medicare, Medicaid, and other HCBS?
2.9.5	Is the IDT aware of condition-specific resources that might assist older adults and their caregivers to meet their financial needs?

2.10 Ombudsman

Subdomain 2.10 assesses the organization's knowledge of ombudsman programs to assist individuals in resolving problems (e.g., individual complaints, grievances, appeals, inquiries) with health care providers—including payers, SNFs, and assisted living facilities. Ombudsman programs vary by state, but ACL supports a National Long-Term Care Ombudsman Resource Center, which can help you find LTC ombudsman programs in your state.[102]

Section	2.10 Ombudsman: GSCA Question Text
2.10.1	Does the IDT help individuals connect with ombudsmen to resolve payer, provider, or LTC facility problems?

2.11 Health Insurance Portability and Accountability Act (HIPAA)

Subdomain 2.11 assesses the organization's familiarity with HIPAA protections, including regulation of privacy and security of an individual's protected health information (PHI)—which covers use and sharing of EHRs with authorized personnel, the individual's right to obtain their health records, and an individual's ability to request corrections.[103, 104]

All health care organizations train staff about HIPAA Title II privacy and security regulations. IDT members must follow organization protocols to prevent or remediate privacy violations. They can inform individuals of their rights under HIPAA to access their health information and release selected information to family or other designated individuals. Staff should ask the individual to complete medical and health information release forms. State laws might also include additional protections for PHI related to psychiatric diagnosis and treatment or other conditions.

Section	2.11 Health Insurance Portability and Accountability Act (HIPAA): GSCA Question Text
2.11.1	Are IDT staff knowledgeable about HIPAA Title II regulations regarding individual PHI?
2.11.2	Do IDT staff honor and facilitate the release of PHI to the individual?

2.12 Health Information Technology

Subdomain 2.12 assesses the various elements of the older adult's EHR, including assessments, the care plan, medication lists, referrals and authorizations, care management notes, and other information, as appropriate. Ideally, the IDT uses an EHR that can incorporate information from all providers and settings engaged in the individual's care. Keeping this information in an EHR supports communication

and coordination, but some individuals involved in an older adult's care will have no capability to access or generate electronic records.

Electronic Health Records. Geriatric-competent organizations commonly provide key information in a readily accessible location (e.g., virtual front page, summary screen) of the individual's EHR. If the organization uses paper medical records, the IDT should have protocols in place and a means to efficiently share key information. Person-centered organizations will enhance care coordination by including data it collects from the individual's caregivers. The IDT will also take steps to routinely verify and update the record with ongoing caregiver feedback.

Data Analysis. Organizations might find that analyzing cost and utilization data (e.g., data from ED visits, specialty referrals, behavioral health services, pharmaceutical services, inpatient hospital admissions, LTSS use, care management contacts, risk indicators) can populate person-specific reports that can inform IDTs. Data analyses can also help an organization identify opportunities to improve health education or individual support efforts that might prevent future hospital admissions for ambulatory care–sensitive conditions. Additionally, real-time pharmaceutical data can identify treatment changes and plan adherence, which supports comprehensive medication management. Predictive modeling might identify key variables associated with health care and LTSS use, enabling providers to fine-tune care plans and improve outcomes.

Section	2.12 Health Information Technology: GSCA Question Text
2.12.1	Is all information (e.g., medical, social, medications, financial) for each individual documented, maintained, and updated within the paper or electronic health record (EHR)?
2.12.2	If your organization maintains EHRs, are they interoperable with EHRs of key providers involved in the individual's care?
2.12.3	Does an IDT member or support person specifically manage, update, and disseminate each individual's information to appropriate providers as discussed with and approved by the individual themself?
2.12.4	Does your organization have a means to quickly access, communicate, and disseminate key individual information, especially for anyone providing after-hours coverage?
2.12.5	Can an individual access all components of their health record?
2.12.6	Does your organization document informal caregivers in the medical record?
2.12.7	Does the IDT routinely review use data in the health record to identify areas for clinical intervention and QI?
2.12.8	Does your organization routinely provide relevant clinical and use data to external providers to identify opportunities for improvement?

Domain 3: Care Management and Care Planning

Domain 3 assesses an organization's ability to provide adequate care management and planning. Questions in this domain of the GSCA Tool include care planning design, oversight, and coordination; care transitions; medication management; and care management.

Domain 3 Considerations for Organizations Serving Dually Eligible Older Adults

- What questions could your IDT members ask when developing care plans for dually eligible older adults to enlist appropriate supports and maximize compliance?
- What resources are available to IDT members (e.g., lists of geographically accessible in-network specialists) when they create and update care plans for dually eligible older adults?
- Does your organization train IDT members to understand how to maximize coverage and minimize out-of-pocket expenses for dually eligible older adults?
- Are leadership and staff aware of specific challenges facing older dually eligible individuals? What protocols does your organization have in place to ensure it prioritizes those needs?

3.1 Care Planning

Subdomain 3.1 focuses on elements of the care plan—that is, the guiding document that identifies all the care, services, and supports for each individual. It is a person-centered, dynamic document that the IDT references, reviews, and revises over time, depending on the older adult's needs and goals.

To ensure equitable care management, plans must center on the individual's goals, expectations, and realities. However, geriatric-competent organizations also provide their staff with specific training and coaching on how to sensitively address an individual who may disagree with clinical recommendations. Staff discuss the individual's concerns and explain benefits and risks when developing care plans, bolstering the individual's understanding of the suggested course of treatment. This contributes to a meaningful dialogue between the provider and individual, leading to a stronger mutual understanding of care plan goals which, in turn, can help the individual better manage their care.[105] Automated reminders prompting IDT members to review and update the care plan may also be helpful.

Accounting for social risk factors (e.g., SDOH) when developing care plans can improve health equity by addressing key drivers of poor health.[106] Geriatric-competent organizations are mindful of SDOH as they build accountability and timeframes into care plans.

Section	3.1 Care Planning: GSCA Question Text
3.1.1	Are the individual's care goals, action steps to meet those goals, and proposed interventions to overcome identified challenges documented in the care plan?
3.1.2	Does the care plan contain specific documentation of what formal (paid) and informal (unpaid) care and supports the individual needs, as well as what care and support services the individual is receiving?
3.1.3	Do IDT members take steps to ensure that individuals understand and feel empowered to accept, negotiate, or modify changes made to their care plan?
3.1.4	Do individuals and all members of the IDT have full access (either electronically or on paper) to the initial care plan and any subsequent changes or updates to it?
3.1.5	Does your organization account for social risk factors when developing the individual's care plan?

3.2 Care Plan Oversight and Coordination

Subdomain 3.2 assesses how well the organization supports IDT members who care for older adults. These providers are responsible for maintaining the care plan and overseeing its implementation. They must ensure it reflects evolving needs and risk factors, which in turn helps support individual engagement with care plan goals and strengthen trust between individuals and their care providers. It is helpful for organizations to ensure that IDT members are informed of changes to an individual's health status. Transparency and communication are both critical to most efficiently empower team members

who work directly with the older adult. Clinical decision aids (e.g., EHR reminders) can also help the IDT provide timely care and ensure that the individual's care plan remains current.

Section	3.2 Care Plan Oversight and Coordination: GSCA Question Text
3.2.1	Does your organization have a mechanism to alert IDT members when a change occurs in an individual's health status or care needs that affect the care plan (e.g., sharing admission, discharge, and transition—or ADT—information)?
3.2.2	Does your organization provide the IDT with clear criteria to determine when a change in an individual's health, condition, or caregiver status requires care plan revisions?
3.2.3	Does your organization provide timely reminders or prompts to IDT members that can help guide their work with each person and improve the individual's engagement with care plan goals?

3.3 Care Transitions

Subdomain 3.3 focuses on supporting successful care transitions (i.e., the movement of an individual from one health care provider or setting to another) for older adults. Care transitions can pose opportunities for care and medication regimen disruptions. Poorly handled transitions often lead to acute care readmissions. For all these reasons, IDT members must be particularly vigilant during transitions to preserve the individual's safety and wellbeing.

Geriatric-competent organizations can mitigate risks by anticipating challenges ahead of time by preparing transition plans within the individual's broader care plan. IDTs should develop transition plans that consider the individual's likely needs holistically by identifying and addressing potential barriers to engaging with their care plan goals (e.g., medication costs, transportation to follow-up care) and ensuring clear communication among health care teams and among the providers, individuals, and family members.[107,108] Organizations might wish to consult evidence-based and validated interventions,[109] such as Project BOOST ("Better Outcomes for Older Adults through Safer Transitions") or MATCH ("Medications at Transitions and Clinical Handoffs") to support IDTs in managing care transitions.[110]

Section	3.3 Care Transitions: GSCA Question Text
3.3.1	Does your organization have explicit protocols to assist IDT members in managing care transitions?
3.3.2	Does the individual's care plan include a transition plan that accounts for all anticipated significant changes (e.g., deteriorating health status)?
3.3.3	Does your organization assign the individual an IDT member to take responsibility for ensuring successful care transitions and timely follow-up?
3.3.4	Does a significant change in the individual's functional capacity trigger discussion about potentially establishing a care transition plan?
3.3.5	Does the IDT collaborate with and provide resources to caregivers to assist with transitions?

3.4 Medication Management

Subdomain 3.4 explores the organization's medication management training. Geriatric-competent organizations provide training and reinforce guidelines in comprehensive medication management, including medication review, medication reconciliation, and medication discontinuation or tapering.

These steps might require the IDT to consult with a clinical pharmacist to address or prevent polypharmacy-related complications. Keeping an open line of communication with the older adult, their caregiver, and their PCP can help further support effective medication management.

Section	3.4 Medication Management: GSCA Question Text
3.4.1	Are all medications reviewed at assessment, reassessment, transitions, and when a significant change occurs in the older adult's condition?
3.4.2	Do IDTs confer with pharmacists to assess and address polypharmacy or inappropriate prescribing?
3.4.3	Is the individual's PCP informed when another practitioner orders a medication change?
3.4.4	Are individuals and their caregivers trained in medication administration, if needed?
3.4.5	Do IDT members routinely review an individual's medications?

3.5 Care Management

Subdomain 3.5 focuses on how well the organization manages assessing, updating, and meeting the care needs of older adults. Older adults often have preferences regarding how and where they receive care; effective care management solicits the older adult's input to inform and tailor their care plan.

Section	3.5 Care Management: GSCA Question Text
3.5.1	Does your organization have a process to determine an individual's initial level of care management needs?
3.5.2	Does the IDT's assessment process for care management incorporate the individual's expectations and preferences for determining care management support?
3.5.3	Does the IDT discuss the individual's care management expectations during all reassessments and confirm that the individual is receiving the appropriate level and nature of care management services in a timely fashion?
3.5.4	Does the IDT ask the individual how often they would like the IDT to contact them?
3.5.5	Does the IDT advise individuals on when and how to obtain care management support?

Domain 4: Referral and Community Engagement

Domain 4 assesses an organization's ability to refer older adults to community resources. The language below, as well as the associated questions in the GSCA Tool, address network composition and capacity, HCBS, LTSS, mobility equipment, home modifications, transportation services, employment support, advance directives, and alternative living arrangements.

4.1 Network Composition and Capacity

Subdomain 4.1 helps organizations map their referral network and better understand their ability to help their members gain access to HCBS and social services. Home and community-based LTSS include in-home supports, skilled nursing, personal care assistance, durable medical equipment and supplies, home health, hospice, home chores, adult day health, adult foster care, community-based transportation, housing, and social programs. The individual's goals and priorities, as identified in the assessment and care planning process, must drive the development of the individual's person-centered care plan.

Although the PCP has not historically been responsible for LTSS network capacity, organizations with geriatric capacity might consider hiring or contracting with community-based LTSS providers to best serve older adults. Moreover, because research suggests that LTSS delivered in the home and in the community improves health outcomes and reduces care costs, particularly for individuals who have complex health and social needs, it holds significant promise for providers and consumers of health care.[111]

Integrating social services into health care requires thorough planning and assessment, expert knowledge of the social service system, ongoing case management, and accountability for service delivery and outcomes.[112] To optimally serve their older adult population's health and social needs, organizations can consider implementing or bolstering strategies to advance integration across both systems. For example, strategies include partnering with community-based organizations (CBOs). Geriatric-competent organizations can access additional resources on promoting integration between the health and social care systems at the Partnership to Align Social Care.[113]

Organizations also might consider implementing telehealth options that remotely deliver health care, health information, or health education using telecommunications technology. To ensure that older adults have the technological supports they need, organizations might invest in installing, managing, and troubleshooting equipment (e.g., computers, routers, receivers). They might also offer training and education to help ensure that the individuals know how to use the equipment properly. If the community lacks specific services that an individual requires, organizations may engage other CBOs or social agencies in developing the needed services.

Section	4.1 Network Composition and Capacity: GSCA Question Text
4.1.1	Does your organization identify the individual's HCBS needs as a part of the assessment and care planning process?
4.1.2	Does your organization have network capacity to ensure that individuals have access to the full range of needed LTSS (e.g., adequate referral networks, partnerships with CBOs)?
4.1.3	Does your organization have capacity to offer services not readily available in the community that are specified in the individual's care plan?
4.1.4	Does your organization have a mechanism to track health care services that individuals obtain from external specialists, hospitals, or other nonprimary care service delivery infrastructure?

4.2 Home and Community-Based Services (HCBS)

Subdomain 4.2 focuses on the organization's knowledge of patient characteristics that could lead to independent living options with HCBS as well as its ability to educate individuals about such options. HCBS includes a wide range of services and supports provided at home (e.g., personal or home care, home health services, home modifications) and in the community (e.g., transportation, meal services, adult day services). Community settings might include residential settings (e.g., group homes, supported living arrangements, supervised living facilities, assisted living facilities) and nonresidential settings (e.g., day programs, rehabilitative or medical services, job or vocational services). Individuals residing in rural areas often have difficulty accessing HCBS. Increasing quality of and access to HCBS for rural residents has important implications for improving SDOH.

The functional capability of dually eligible older adults living independently (with HCBS LTSS supports) varies widely. Factors that drive that variability include the level of available caregiver assistance, the degree of available and affordable in-home or community-based services, and the accessibility of the individual's home. These variables, as well as available state Medicaid waivers, dictate whether an individual might qualify for reimbursement for certain in-home services or community-based programs that help support their ADLs.

Section	4.2 Home and Community-Based Services: GSCA Question Text
4.2.1	Does your organization offer information and resources about HCBS in the community?
4.2.2	Is the IDT familiar with the functional capabilities a person needs to live independently with HCBS?

4.3 Self-Directed Option for HCBS

Subdomain 4.3 considers how organizations can assess their ability to support individuals who elect a self-directed option for HCBS. This model of HCBS LTSS care allows the individual to design and direct their own community-based support services, often using a defined annual (or monthly) budget. These services frequently include PCAs, day activities, and homemaker services.[114]

The self-directed model can be beneficial for individuals living where direct care workers are scarce (e.g., rural areas), in part because it promotes a nontraditional workforce of friends and relatives. As either a common law or joint employer, the self-direction option frequently offers individuals the ability to recruit, interview, hire (or refer for hire), determine workers' terms and conditions, supervise workers' day-to-day activities, evaluate job performance, and discharge workers from the home. To promote continuity of care, many geriatric-competent organizations consider allowing individuals to continue with whatever supports they had in place before changing insurers. In some cases, the organization might have to offer individuals extra support (e.g., training; guidance on recruitment, hiring, or supervision; establishing emergency backup plans; helping prevent abuse and neglect).

Section	4.3 Self-Directed Option for HCBS: GSCA Question Text
4.3.1	Does the self-directed option allow individuals to be responsible for hiring, discharging, training, and supervising community-based support workers?
4.3.2	Is skills training and support provided for individuals choosing the self-directed option?
4.3.3	Is a fiscal intermediary or co-employment agency available to support the employer functions of the individual, if needed?

4.4 Agency Model

Subdomain 4.4 includes questions to help organizations evaluate their role in supporting care for people who choose to receive HCBS through a home health care agency (rather than the self-directed option for HCBS, as described in Subdomain 4.3). Alternatives to the self-directed HCBS model involve contracting with a traditional home-based care agency. Under the agency model, an individual enters into a contract with a business that employs PCAs or home health aides to provide care in the individual's residence. Ideally, agency-employed PCAs receive training in geriatric-specific topics, including person-centered care and care of persons with dementia or mild cognitive impairment.

Although PCAs, direct care workers, and home health aides working for an agency are not directly integrated into the IDT, they can offer an important perspective on the individual's needs. With the individual's explicit approval, geriatric care plans often involve care managers and direct care providers in the assessment and care planning process.

Section	4.4 Agency Model: GSCA Question Text
4.4.1	Does the individual have a reasonable choice of providers?
4.4.2	Does the home health care agency assume responsibility for orientation, training, and ongoing supervision of an individual's direct care workers?
4.4.3	If they are not directly involved with the IDT, are direct care workers or their supervisors included in interactions with the IDT?

4.5 Personal Care Assistants

Subdomain 4.5 assesses how the organization supports IDT collaborations with PCAs, particularly during care transitions. PCAs are key contributors to care teams for dually eligible and other older adults.

Health plans that leverage PCAs must ensure care coordination during transitions or when onboarding new PCAs. Should the individual employ their own PCA through the self-directed model or using private funds, it is still important that the IDT coaches the PCA on how to use the care plan.

Geriatric-competent organizations provide training materials for both individuals and their informal caregivers to support communication and clarity of roles and expectations. Training materials often include specific geriatric competencies (e.g., communication skills with older adults, skin care, positioning and transfer techniques, person-centered care, working with individuals with dementia and their families).[115]

Section	4.5 Personal Care Assistants: GSCA Question Text
4.5.1	Does your organization develop a specified transition plan before implementing any changes in the individual's PCA service or model of care?
4.5.2	Is the individual's care plan available to the PCA (and other caregivers, as appropriate) to direct day-to-day personal care service delivery?
4.5.3	Are home-based PCAs trained to deliver services and supports based on the individual's specific care plans?
4.5.4	Does your organization provide training materials for both individuals and their informal caregivers?

4.6 Mobility Equipment, Home Modifications, and Supplies

Subdomain 4.6 focuses on an organization's capacity to facilitate consistent access to medical equipment and supplies. Geriatric-competent organizations need access to multiple suppliers to ensure they can respond quickly to durable medical equipment needs, including repair requests. Access to loaner equipment (e.g., wheelchairs) and same-day delivery of necessary supplies is important, regardless of repair timeline. Some organizations with geriatric expertise have found providing a manual backup wheelchair best for all individuals who routinely use a power chair.

Section	4.6 Mobility Equipment, Home Modifications, and Supplies: GSCA Question Text
4.6.1	Do individuals have access to customized equipment and equipment modifications based on their needs and goals as described in the care plan?
4.6.2	Is an adequate network of equipment providers available to ensure choice and timely access to services?
4.6.3	Are repair requests for durable medical equipment addressed in a timely manner so as not to disrupt or limit the individual's daily functioning?
4.6.4	Are backup options in place for all essential equipment and supplies?

4.7 Transportation Services

Subdomain 4.7 assesses the organization's role in supporting the transportation needs of the individuals within its care. An individual's care plan should specify the type of equipment and assistance needed while being transported. Should the individual be unable to drive their own vehicle (due to, for example, cognitive impairment), accessible public transportation might be a cost-effective option for routine or social travel, although individualized and supported transportation might be required for medical appointments or care (e.g., ambulance, taxi, paratransit services,[116] privately owned vehicles, ridesharing). Organizations should consider that individuals in rural areas face additional transportation barriers, such as lack of public transportation and variable roadway conditions, and must drive longer distances on average to receive services.[117] The IDT will want to understand that the payment for transportation varies from state to state if Medicaid covers these expenses. The organization can

support the individual in exploring creative solutions to pay for transportation needs, such as using local programs that reimburse a driver assisting an older adult or religious organizations responding to a specific request.

In addition to access to transportation support services, organizations with geriatric capacity must ensure the individual understands how to access transportation for all needs (daily, episodic, and urgent). A designated staff member often provides scheduling support. Outside regular office hours, only ambulance transport is generally available. Transportation services to and from medical appointments are offered through local AAAs, including those in rural areas that might have less access to other transportation services.[118]

Organizations serving older adults can monitor transportation vendors for professionalism, timeliness, safety, dependability, and accessibility. They also might wish to ensure that transportation vendors understand curb-to-curb versus door-to-door transport. To help ensure high-quality performance, an organization might wish to periodically seek feedback from the individuals using specific transportation providers.

Section	4.7 Transportation Services: GSCA Question Text
4.7.1	Did the IDT's initial assessment identify specific transportation requirements for the individual?
4.7.2	Are a range of transportation services available to individuals?
4.7.3	Is transportation scheduling support available for individuals?
4.7.4	Are transportation services available 24/7 to meet urgent needs?
4.7.5	Does your organization have clear policies regarding transportation assistance to health care appointments?
4.7.6	Does your organization monitor transportation providers to ensure that their services are safe, dependable, and accessible?

4.8 Employment Supports

Subdomain 4.8 assesses employment supports—which include a variety of services that generally assist individuals in community integration and specifically help people obtain or maintain a job (e.g., transportation to and from work, accommodations for rest periods during a shift, job placement, coaching services).[119,120] These supports may complement HCBS efforts, which also provides habilitation services that help an individual gain and retain employment.[121]

> **Employment or volunteer work** is often an integral component of an individual's health, wellness, and independence. Many dually eligible individuals might depend on part-time jobs to support themselves, despite health problems or functional limitations.

Section	4.8 Employment Supports: GSCA Question Text
4.8.1	Does your organization help individuals access employment services and supports, if desired?

4.9 Advance Directives

Subdomain 4.9 helps organizations assess their knowledge and documentation around advance directives. An advance directive is a legal document that is effective if the individual becomes incapacitated and unable to speak for themselves. An advance care directive includes two elements—a living will and a durable power of attorney for health care. Additionally, some states also have statutes that allow for a psychiatric advance directive (PAD), or durable power of attorney, a legal document that states the individual's preferences for future mental health treatment or names someone to make

treatment decisions if the individual is in a crisis and unable to make decisions.[122] Geriatric-competent organizations ensure that their staff are knowledgeable about advance directives and resources to which they can direct individuals and family members to obtain guidance or legal advice when completing a living will, a durable power of attorney for health care, a durable power of attorney for mental health care or a PAD.

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. Staff at nonclinical organizations with geriatric capacity might have protocols in place that direct the process of connecting the individual to the appropriate medical or mental health assessment, if conditions make it likely that a proxy for health care decision-making is necessary.

Providing signed copies of advance directives and other end-of-life documents is helpful for the individual's PCP (if they are not a member of the IDT) and for the individual's preferred hospital so it can be entered into the EHR.

Section	4.9 Advance Directives: GSCA Question Text
4.9.1	Do IDT staff know whom to contact or refer the older adult to for assistance with a living will, a durable power of attorney for health care, or a durable power of attorney for mental health care?
4.9.2	Does the IDT know how to assess when to institute a living will, a durable power of attorney for health care, or a durable power of attorney for mental health care?
4.9.3	Does your organization require that all completed advance directives be documented in the individual's health record for access by all providers, including those providing after-hours care?

4.10 Alternate Living Arrangements

Subdomain 4.10 evaluates how well the organization supports older adults, including dually eligible individuals, as they explore alternate living arrangements. The IDT should collaborate with the individual and all concerned care partners to ensure the individual's safety, quality of life, and placement in the least restrictive care setting of their preference. Providers should be knowledgeable about different living arrangements available in the community and should assist individuals in navigating them.

Additionally, IDT members should help educate individuals and their families about the services offered at each residential option—such as medication management and staff training—and provide guidance on associated costs and transition support. Local aging networks and geriatric care agencies can be valuable resources for additional information on these options.

> Familiarity with an individual's capabilities helps facilitate care setting assessments. As an older adult's abilities change, the organization should ensure living arrangements continue to meet the individual's safety and wellbeing needs.

To ensure a good fit, health care providers and social service personnel can encourage older adults and their caregivers to visit the living options, meet the staff, and ask questions—particularly about autonomy, activities, and involvement in the residential community. Additionally, the CMS Five-Star Quality Rating System is a useful reference for reviewing a nursing facility's quality of care.[123]

The GSCA identifies several major types of living arrangements. Ordered from least to most restrictive, these include living alone or with family or friends; board and care homes; congregate housing facilities; assisted living and residential living facilities; residential behavioral health treatment centers, state Veterans Homes, and nursing facilities.

Living Alone, with a Family Member, or with a Friend or Friends. Older adults with higher functional ability and available caregiver support might opt to live alone or with family or friends. Other choices

that afford the individual significant autonomy include community-based options, such as cohousing, house sharing, or retirement communities tailored to specific interests or needs.

Board and care homes (also called *adult foster homes*) offer group living arrangements for individuals who need assistance with daily activities but require a lower level of care. Typically accommodating five to six residents, these homes offer support with meals, laundry, transportation, and socialization within a private residence setting.

Congregate housing facilities offer private accommodations with some shared living spaces and some amenities—such as daily meals, social activities, and housekeeping. Although they might provide limited assistance with ADLs, they are not staffed by health care professionals and do not offer 24-hour supervision or health care services.

Assisted living facilities and residential facilities offer housing and support services for six or more residents needing assistance with tasks like cooking, laundry, and medication management.

Residential treatment centers cater to individuals with mental health conditions, including substance use disorder. Also known as rehabilitation programs, these facilities provide tailored treatment plans, often emphasizing slower-paced and repetitive approaches. Individuals and their families should discuss this option with providers who are familiar with state regulations, can discuss different levels of treatment offered at the center, and collaborate with behavioral health practitioners when recommending residential treatment options.[124]

State Veterans Homes, owned and operated by state governments, offer skilled nursing, domiciliary care, and adult day services for eligible Veterans, spouses, and Gold Star parents.[125] Department of Veterans Affairs (VA) social workers are often the best resource for further information. The National Association of State Veterans Homes maintains a list of facilities on its website.[126]

Nursing facilities (or nursing homes) offer both long- and short-term residential care for individuals with limited functional ability to care for themselves at home.[127] Skilled care might be available in designated wings within nursing homes, staffed by nursing assistants overseen by licensed vocational or registered nurses, with medical director oversight.

Section	4.10 Alternate Living Arrangements: GSCA Question Text
4.10.1	Does your organization offer information and resources about living with a family member or with a friend or friends?
4.10.2	Does your organization offer information and resources regarding board and care homes or adult foster homes?
4.10.3	Does your organization offer information and resources about congregate housing facilities or refer the individual to someone who can assist them with this living option?
4.10.4	Does your organization offer information and resources about assisted living facilities and residential facilities?
4.10.5	Does your organization offer information and resources about residential treatment centers?
4.10.6	Does your organization offer information and resources about State Veterans Homes?
4.10.7	Does your organization offer information and resources about nursing homes?

Appendix: References and Resources

RIC includes in this Appendix the sources it consulted while developing the updated GSCA User Guide and Tool, clustered below by domain for ease of use. These sources include government websites, resources provided by professional organizations, and publications in academic journals and the grey literature (e.g., research produced by government or nonprofit organizations). Further below in this User Guide, endnotes document citations in sequential order.

RIC's 2023 environmental scan identified and synthesized principles of several key frameworks that informed the GSCA's goals and organization. For example, IHI's 4Ms Framework of an Age-Friendly Health System offers core goals and structure to the GSCA.[128] RIC also leveraged components of frameworks related to the federal Department of Health and Human Services, including the CMS Framework for Health Equity.[129] It also reviewed the CMS-funded Guide to Reducing Disparities in Readmissions, which offers a person-centered framework for reducing disparities within the Medicare population.[130] HRSA's Advancing Health Center Excellence Framework offers a conceptual structure for defining excellence in health center functioning,[131] while NIA's Health Disparities Research Framework includes assessment questions pertaining to older adults' environmental, sociocultural, behavioral, and biological causes for disparities.[132]

HRSA and NIA's work, in particular, informed GSCA question development around equity and quality improvement activities. Each GSCA domain positions health equity as a key consideration for improving both quality and competence of care for older adults. These foundational frameworks unite the GSCA domains under the common theme of health equity.

Part A: Preassessment Background and Framing

Topic	Titles and Links
Geriatric Competencies	• American Geriatrics Society's Summary of Core Competencies • RIC's Caring for Individuals with Alzheimer's Disease and Related Dementias

Quality Improvement Resources	• Institute for Healthcare: Featured Quality Improvement Tools
	  o Driver Diagram
	  o Quality Improvement Project Measures Worksheet
	  o Plan-Do-Study-Act (PDSA) Worksheet
	  o "Seven Spreadly Sins"
	• AHRQ's Health Literacy Universal Precautions Toolkit, 2nd Edition
	• Hartford Institute for Geriatric Nursing's Elder Mistreatment Assessment
	• AHRQ's Care Management – An Implementation Guide for Primary Care Practices
	• Healthy People 2030's Older Adults Evidence-Based Resources

Age-Friendly Health Systems	• IHI's Age-Friendly Health Systems • IHI's Resources to Practice Age-Friendly Care

Domain 1: Person-Centered Approach

Topic	Titles and Links
Assessment and Screening Resources	- Alzheimer's Association's Cognitive Screening and Assessment - American Health Care Association and National Center for Assisted Living's CoreQ - AHRQ's Geriatric Depression Scale - Brown University's Toolkit of Instruments to Measure End of Life Care - CMS' CAHPS® Hospice Survey - CMS' Medicare Coverage Determination Process - Spanish and English Neuropsychological Assessment Scales[133] - Stanford University's Geriatric Assessment - The Cognitive Abilities Screening Instrument (CASI)[134] - The Cross-Cultural Neuropsychological Test Battery (CCNB)[135] - Westmont College's Spiritual Well-Being Scale
Implicit Bias	- American Academy of Family Physicians' Implicit Bias Training ("The EveryONE Project") - IHI's How to Reduce Implicit Bias - Twelve Tips for Teaching Implicit Bias Recognition and Management[136]
Individual Centered Practice	- AHRQ's Working for Quality - American Geriatrics Society's Person-Centered Care: A Definition and Essential Elements - IHI's How to Have Conversations with Older Adults About "What Matters" - IHI's "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults - John A. Hartford Foundation's Age-Friendly Care: It's About What Matters to You - Patient-Centered Care: What It Means And How To Get There[137] - Patient and Family Engagement[138]
Cultural Competency	- ACL's Cultural Competency Guide for Beneficiary Counseling & Ombudsman Programs - AHRQ's Cultural Competence and Patient Safety - AHRQ's Culturally and Linguistically Appropriate Services - ACL's Diversity and Cultural Competency
Advance Care Planning	- NIA's Advance Care Planning: Advance Directives for Health Care - The Conversation Project's Your Conversation Starter Guide - The VA's Making Decisions: Advance Care Planning
Caregiving Resources	211's Caregiver Resources available through 211 - AARP's Caregiving Homepage - ACL's Support to Caregivers - ACL's RAISE Family Caregivers Act Initial Report to Congress - Alzheimer's Association's Educational Programs and Dementia Care Resources - Alzheimer's Association's Respite Care - Family Caregiver Alliance's Homepage - Family Caregiver Alliance's Dementia with Lewy Bodies - National Alliance for Caregiving's Care for the Family Caregiver - National Alliance for Caregiving's Caregiving in Rural America - New York University's Modified Caregiver Strain Index (MCSI) - National Alliance for Caregiving's Caregiver Self-Assessment Questionnaire - National Alliance for Caregiving's Caring For The Caregiver - NIA's Caregiving Homepage - NIA's Caring for a Person with Alzheimer's Disease - Rural Health Information Hub's Caregivers and Caregiver Well-Being

Topic	Titles and Links
Prescribing	• American Family Physician's Polypharmacy: Evaluating Risks and Deprescribing • National Board of Medication Therapy Management's Medication Therapy Management • World Health Organization's Medication Safety in Transitions of Care

Domain 2: Interdisciplinary Care Team Capacity and Organization Infrastructure

Topic	Titles and Links
Telemedicine	• The National Consortium of Telehealth Resource Centers Homepage • Rural Health Information Hub's Telehealth/Home Health Homepage • Rural Health Information Hub's Technology Homepage
Ombudsman	• ACL's Long-Term Care Ombudsman Program • CMS' Medicare Beneficiary Ombudsman (MBO) Homepage
HIPAA	• CMS' HIPAA Administrative Simplification Regulations Overview • HHS' The HIPAA Privacy Rule

Domain 3: Care Management and Care Planning

Topic	Titles and Links
Care Management	• AHRQ's Teach-Back: Intervention • Collaboration for Home Care Advances in Management and Practice's Geriatric Care Transitions Toolkit • RIC's Interdisciplinary Care Teams for Older Adults: Resource Guide • Telemedicine and the Interdisciplinary Clinic Model: During the COVID-19 Pandemic and Beyond[139] • The Worldwide Impact of Telemedicine during COVID-19: Current Evidence and Recommendations for the Future[140]
Medication Management	• American Geriatrics' For Older People, Medications Are Common; Updated AGS Beers Criteria® Aims to Make Sure They're Appropriate, Too • American Geriatrics' Geriatric Medication Management Toolkit • American Geriatrics' What Older Adults Can Do To Manage Medications • Medication Management in Older Adults[141] • RIC's Safe And Effective Use Of Medications In Older Adults

Domain 4: Referral and Community Engagement

Topic	Titles and Links
Community-Based Partnerships	• Partnership to Align Social Care's List of Resources • CDC Foundation's Recommendations for Strengthening Partnerships Between Health Departments and Community-Based Organizations
HCBS Resources	• National Council on Aging's What Is a Dual Eligible Special Needs Plan (D-SNP)? • RIC's Introduction to Home and Community-Based Services (HCBS): Key Considerations for Health Plans
Financial Supports	• Alzheimer's Association's Managing Money Online: A Free Online Program for Caregivers • Consumer Financial Protection Bureau's Managing Someone Else's Money • NIA's Legal and Financial Planning • Rural Health Information Hub's Rural Funding & Opportunities

Topic	Titles and Links
Housing and Utility Supports	• ACF's Low Income Home Energy Assistance Program (LIHEAP) • Rural Health Information Hub's Sustainable Home Environment Solutions • U.S. Department of Housing and Urban Development's Housing Choice Vouchers Fact Sheet • U.S. Department of Housing and Urban Development's Section 202 Supportive Housing for the Elderly Program • U.S. Department of Housing and Urban Development's Section 231 Mortgage Insurance for Rental Housing for the Elderly • USDA's Single Family Housing Repair Loans & Grants • USDA's Single Family Housing Direct Home Loans • USDA's Rural Rental Assistance Program
Transportation Resources	• ACL's Older Americans Act—Transportation FAQs • National Aging and Disability Transportation Center's Resources & Publications • Rural Health Information Hub's Transportation Programs
Advance Directives	• AARP's Find Advance Directive Forms by State • Substance Abuse and Mental Health Services Administration's A Practical Guide to Psychiatric Advance Directives
Alternate Living Arrangements	• AARP's Your Home Checklist for Aging in Place • ASPE's Licensed Board and Care Homes • CMS' Finding a Nursing Home • CMS' Nursing Home Checklist • CMS' What Are My Other Long-Term Care Choices? • National Association of State Veterans Homes' Website • NIA's Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care • The VA's State Veterans Homes
Substance Use	• AHRQ's Prevention, Diagnosis, and Management of Opioids, Opioid Misuse, and Opioid Use Disorder in Older Adults • SAMHSA's Referral and Treatment Approaches[142]

References

[1] U.S. Census Bureau, Decennial Census 2000, Table DP1 and American Community Survey 1-year estimates, 2010 and 2021, Table S0101; Projected Age Groups and Sex Composition of the Population: Main Projections Series for the United States, 2017-2060, Table 2. As cited in the 2023 National Healthcare Quality and Disparities Report (ahrq.gov). Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2023-nhqdr.pdf.

[2] Administration for Community Living. (2022). *2021 Profile of Older Americans.* Retrieved from https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans.

[3] Administration for Community Living. (2006). *2005 Profile of Older Americans*. Retrieved from https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans.

[4] Agency for Healthcare Research and Quality. (2023). *National Healthcare Quality and Disparities Report*. Retrieved from https://www.ahrq.gov/research/findings/nhqrdr/nhqdr23/index.html.

[5] Ansah, J. P., & Chiu, C. T. (2023). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*, *10*, 2296–2565. Retrieved from https://doi.org/10.3389/fpubh.2022.1082183.

[6] American Geriatrics Society. (n.d.). Core Competencies: Existing Formal Geriatrics Competencies and Milestones. Retrieved from https://www.americangeriatrics.org/geriatrics-profession/core-competencies; See also: Association of Directors of Geriatric Academic Programs (2021). Geriatric Competencies for Medical Students. Retrieved from https://adgap.americangeriatrics.org/education-training/competencies/geriatrics-competencies-medical-students.

[7] Centers for Medicare & Medicaid Services. (2016). *Person and Family Engagement Strategy*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy.pdf.

[8] van Hasselt, M., McCall, N., Keyes, V., Wensky, S. G., & Smith, K. W. (2015). Total cost of care lower among Medicare fee-for-service beneficiaries receiving care from patient-centered medical homes. *Health Services Research, 50*(1), 253–272. Retrieved from https://doi.org/10.1111/1475-6773.12217.

[9] Liao, L., Feng, M., You, Y., Chen, Y., Guan, C., & Liu, Y. (2023). Experiences of older people, healthcare providers and caregivers on implementing person-centered care for community-dwelling older people: a systematic review and qualitative meta-synthesis. *BMC geriatrics, 23*(1), 207. Retrieved from https://doi.org/10.1186/s12877-023-03915-0.

[10] Lee, K. H., Lee, J. K., & Kim, B. (2022). Person-Centered Care in Persons Living With Dementia: A Systematic Review and Meta-analysis. *The Gerontologist, 62*(4), e253–e264. Retrieved from https://doi.org/10.1093/geront/gnaa207.

[11] Chenoweth, L., Williams, A., Fry, M., Endean, E., & Liu, Z. (2022). Outcomes of Person-centered Care for Persons with Dementia in the Acute Care Setting: A Pilot Study. *Clinical Gerontologist, 45*(4), 983–997. Retrieved from https://doi.org/10.1080/07317115.2021.1946233.

[12] Rowe, J. W., Berkman, L., Fried, L., et al. (2016). Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care. *National Academy of Medicine Perspectives.* Retrieved from https://doi.org/10.31478/201609n.

[13] Centers for Medicare & Medicaid Services. (n.d.). Seniors & Medicare and Medicaid Enrollees. Retrieved from https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html.

[14] Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination office (MMCO). (2020). *Data Analysis Brief: Medicare-Medicaid Dual enrollment 2006 through 2019.* Retrieved from https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.

[15] Pena, M. T., Mohamed, M., Burns, A., Fuglesten Biniek, J., Ochieng, N., & Chidambaram, P. (2023). A Profile of Medicare-Medicaid Enrollees (Dually eligibles). *Kaiser Family Foundation*. Retrieved from https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

[16] Ibid.

[17] Oh, N. L., Potter, A. J., Sabik, L. M., Trivedi, A. N., Wolinsky, F., & Wright, B. (2022). The association between primary care use and potentially-preventable hospitalization among dual eligibles age 65 and over. *BMC Health Services Research, 22*(1), 927. Retrieved from https://doi.org/10.1186/s12913-022-08326-2.

[18] Ibid.

[19] Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission (20 *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Retrieved from https://www.medpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508_SEC.pdf.

[20] Ibid.

[21] Centers for Medicare & Medicaid Services. (2023). *CMS Strategic Plan for Health Equity Fact Sheet.* Retrieved from https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.

[22] Agency for Healthcare Research and Quality (2023).

[23] Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission (2024).

[24] Pena, Maria. (2023).

[25] Institute for Healthcare Improvement. (n.d.). Age-Friendly Health Systems. Retrieved from https://www.ihi.org/networks/initiatives/age-friendly-health-systems.

[26] Health Resources & Services Administration (2020).

[27] Ebrahimi, Z., Patel, H., Wijk, H., Ekman, I., & Olaya-Contreras, P. (2021). A systematic review on implementation of person-centered care interventions for older people in out-of-hospital settings. *Geriatric nursing, 42*(1), 213–224. Retrieved from https://doi.org/10.1016/j.gerinurse.2020.08.004.

[28] Life Space Assessments measure the frequency, extent, and independence of a person's movements inside and outside of their home environment. See: Baker, P. S., Bodner, E. V., & Allman, R. M. (2003). Measuring life-space mobility in community-dwelling older adults. *Journal of the American Geriatrics Society, 51*(11), 1610–1614. Retrieved from https://pubmed.ncbi.nlm.nih.gov/14687391/.

[29] Pirozzo, S., Papinczak, T., & Glasziou, P. (2003). Whispered voice test for screening for hearing impairment in adults and children: systematic review. *BMJ (Clinical research ed.), 327*(7421), 967. Retrieved from https://doi.org/10.1136/bmj.327.7421.967.

[30] 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.

[31] The GDS, originally created in 1982, is designed to measure symptoms of depression in older adults. It can be found in three forms of varying length. The initial publication is: Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M., & Leirer, V. (1982). Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res, 17*(1), 37–49. Retrieved from https://pubmed.ncbi.nlm.nih.gov/7183759/.

[32] Segal, D. L., June, A., Payne, M., Coolidge, F. L., & Yochim, B. (2010). Development and initial validation of a self-report assessment tool for anxiety among older adults: the Geriatric Anxiety Scale. *Journal of Anxiety Disorders*, *24*(7), 709–714. Retrieved from https://doi.org/10.1016/j.janxdis.2010.05.002.

[33] Morley, J. E., Malmstrom, T. K., & Miller, D. K. (2012). A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. *The Journal of Nutrition, Health & Aging*, *16*(7), 601–608. Retrieved from https://doi.org/10.1007/s12603-012-0084-2.

[34] Hibbard, J. H., Mahoney, E. R., Stockard, J., & Tusler, M. (2005). Development and testing of a short form of the patient activation measure. *Health Services Research*, *40*(6p1), 1918–1930. Retrieved from https://pubmed.ncbi.nlm.nih.gov/16336556/.

[35] Seematter-Bagnoud, L., & Büla, C. (2018). Brief assessments and screening for geriatric conditions in older primary care patients: a pragmatic approach. *Public health reviews, 39*(8). Retrieved from https://doi.org/10.1186/s40985-018-0086-7.

[36] NIA Supports Research on Pain in Older People. (2014). Research Highlights. *National Institute on Aging*. Retrieved from https://www.nia.nih.gov/news/nia-supports-research-pain-older-people.

[37] Noroozian, M., Raeesi, S., Hashemi, R., Khedmat, L., & Vahabi, Z. (2018). Pain: The Neglect Issue in Old People's Life. *Macedonian Journal of Medical Sciences*, *6*(9), 1773–1778. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6182540.

[38] Skinner, T. R., Scott, I. A., & Martin, J. H. (2016). Diagnostic errors in older patients: a systematic review of incidence and potential causes in seven prevalent diseases. *International Journal of General Medicine*, *9*, 137–146. Retrieved from https://doi.org/10.2147/IJGM.S96741.

[39] Ryvicker, M., Gallo, W. T., & Fahs, M. C. (2012). Environmental Factors Associated with Primary Care Access Among Urban Older Adults. *Social Science & Medicine, 75*(5), 914–921. Retrieved from https://doi.org/10.1016/j.socscimed.2012.04.029.

[40] Carpenter, D., Famolaro, T., Hassell, S., Kaeberle, B., Reefer, S., Robins, C., & Siegel, S. (2017). *Patient Safety in the Home*. Institute for Healthcare Improvement. Retrieved from https://www.ihi.org/sites/default/files/2023-10/PatientSafetyInTheHome_2017.pdf.

[41] AARP Livable Communities. (2015). OTs and CAPS Can Make a Home a Good Fit. Retrieved from https://www.alatlanta.com/ots-and-caps-can-make-a-home-a-good-fit.

[42] Mental Health and Development Disabilities National Training Center. (n.d.). Plain Language Summary: Self-Determination & Dignity of Risk. Retrieved from https://www.mhddcenter.org/self-determination-dignity-of-risk/.

[43] Institute for Healthcare Improvement. (2021). *How to Have Conversations with Older Adults About "What Matters": A Guide for Getting Started.* Retrieved from https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/AgeFriendlyHealthSystems_How-to-Have-Conversations-with-Older-Adults-About-What-Matters.pdf.

[44] Office of Healthcare Information and Counseling, Administration for Community Living. (2022). Cultural Competency Resource Guide for Beneficiary Counseling and Ombudsman Programs. Retrieved from https://acl.gov/sites/default/files/programs/2022-08/Cultural%20Competency%20Resource%20Guide%20July%202022.docx

[45] See question 4.1.6 for more information on caregiver backup planning.

[46] Greene, J., & Hibbard, J. H. (2012). Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. *Journal of General Internal Medicine, 27*(5), 520–526. Retrieved from https://doi.org/10.1007/s11606-011-1931-2.

[47] Refer to Domain 4 – Referral and Community Engagement for more information on working with informal caregivers in the care planning process.

[48] Konno, R., Inoue, K., Schultz, T., & Wiechula, R. (2020). Best evidence for advance care planning in older adults with dementia and their families: an umbrella review protocol. *JBI Evidence Synthesis, 18*(4), 841–848. Retrieved from https://pubmed.ncbi.nlm.nih.gov/32813345/.

[49] Brinkman-Stoppelenburg, A., Rietjens, J. A., & van der Heide, A. (2014). The effects of advance care planning on end-of-life care: a systematic review. *Palliative Medicine*, *28*(8), 1000–1025. Retrieved from https://pubmed.ncbi.nlm.nih.gov/24651708/.

[50] See Subdomain 7.2 – Legal Issues for a discussion of advance directives components (e.g., living wills, durable power of attorney for health care and mental health care).

[51] Godfrey, M., Young, J., Shannon, R., Skingley, A., Woolley, R., Arrojo, F., Brooker, D., Manley, K., & Surr, C. (2018). The Person, Interactions and Environment Programme to improve care of people with dementia in hospital: a multisite study. *Health Services and Delivery Research, 6*(23). Retrieved from https://doi.org/10.3310/hsdr06230.

[52] Reaves, E. L., & Musumeci, M. (2015). Medicaid and Long-Term Services and Supports: A Primer. *Kaiser Family Foundation.* Retrieved from https://www.kff.org/report-section/medicaid-and-long-term-services-and-supports-a-primer-report-dec-2015/.

[53] Thach, N. T., & Wiener, J. M. (2018). *An Overview of Long-Term Services and Supports and Medicaid: Final Report*. U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//182846/LTSSMedicaid.pdf.

[54] Chaudhuri, G., Hamman, M. K., Morales, M. J., Robert, S., & Turner, M. (2022). *The Geography of Long-Term Care: Implications for SSI and Understanding Disparities in Living Arrangements Among Older Adults.* University of

Wisconsin-Madison's Retirement & Disability Research Center. Retrieved from https://rdrc.wisc.edu/files/research-briefs/WI22-07_Hamman-et-al_Research-Brief_9.28.22.pdf.

55 Choula, R. (2022). Narrowing the Disparities Gap in LTSS: Policy and Practice. *Innovation in Aging, 6*(Suppl. 1), 148–149. Retrieved from https://doi.org/10.1093/geroni/igac059.592.

56 Gonzalez, C. M., Lypson, M. L., & Sukhera, J. (2021). Twelve tips for teaching implicit bias recognition and management. *Medical Teacher, 43*(12), 1368–1373. Retrieved from https://doi.org/10.1080/0142159X.2021.1879378.

57 Centers for Medicare & Medicaid Services. (n.d.). Self-Directed Services. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html.

58 National Association of Social Workers. (2010). Standards for Social Work Practice with Family Caregivers of Older Adults. Retrieved from https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Social-Work-Practice-with-Family-Caregivers-of-Older-Adults.

59 National Institute on Aging. (n.d.). Talking with Your Older Patients. Retrieved from https://www.nia.nih.gov/health/health-care-professionals-information/talking-your-older-patients.

60 American Geriatrics Society. (2022). Research Presented at #AGS22 Focuses on Prescribing Practices, Early Mobility Programs and Evaluating Mortality and Dementia. Retrieved from https://www.americangeriatrics.org/media-center/news/research-presented-ags22-focuses-prescribing-practices-early-mobility-programs.

61 Fox, M. H., & Reichard, A. (2013). Disability, health, and multiple chronic conditions among people eligible for both Medicare and Medicaid, 2005–2010. *Preventing Chronic Disease, 10*, E157. Retrieved from https://doi.org/10.5888/pcd10.130064.

62 Medicare Payment Advisory Commission (2018). Medicare fee-for-service and managed care enrollment, CY 2013. Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_entirereport_sec_rev_0518.pdf.

63 Budnitz, D. S., Lovegrove, M. C., Shehab, N., & Richards, C. L. (2011). *Emergency Hospitalizations for Adverse Drug Events in Older Americans*. *The New England Journal of Medicine, 365*(21). Retrieved from https://www.nejm.org/doi/pdf/10.1056/NEJMsa1103053.

64 Rochon, P., & Gurwitz, J. (1997). Optimising drug treatment for elderly people: the prescribing cascade. *BMJ (Clinical research ed.)*, *315*(7115), 1096–1099. Retrieved from https://doi.org/10.1136/bmj.315.7115.1096.

65 2023 American Geriatrics Society Beers Criteria® Update Expert Panel. (2023). American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society, 71*(7), 2052–2081. Retrieved from https://doi.org/10.1111/jgs.18372.

66 Centers for Disease Control and Prevention (n.d.). Caregiving. Retrieved from https://www.cdc.gov/caregiving/.

67 See Domain 3 - LTSS for more information on paid HCBS. For information on unpaid caregivers, see the Centers for Disease Control and Prevention (2019).

68 Eldercare Locater is a public service of the Administration on Aging (AoA), an agency of the U.S. Administration for Community Living (ACL) and serves as a referral resource connecting people to local programs and services, including transportation. Eldercare Locator. (n.d.). Retrieved from https://eldercare.acl.gov/Public/Index.aspx.

69 The HIPAA Privacy Rule is the first comprehensive federal protection for the privacy of personal health information. For more information, see https://security.cms.gov/learn/health-insurance-portability-and-accountability-act-1996-hipaa.

70 Rural Health Information Hub. (2019). *Rural Aging in Place Toolkit: Caregivers and Caregiver Well-Being.* Retrieved from https://www.ruralhealthinfo.org/toolkits/aging/2/supporting-caregivers.

71 Easter Seals Disability Services and National Alliance for Caregiving. (2006). *Caregiving in Rural America*. Retrieved from https://www.caregiving.org/wp-content/uploads/2020/05/Easter-Seals_NAC_Caregiving_in_Rural.pdf.

72 Additional sections in this tool related to informal caregiving that may be helpful to review include Question 1.1.3 (involving older individuals, families, and caregivers in care planning), Question 1.7.6 (collaborating and providing resources to the caregiver or family to assist with care transitions), Subdomain 1.11 (interacting with

caregivers), Question 2.3.4 (individual and caregiver training in medication administration), and Subdomain 3.7.4.7 (living with a family member or friend).

[73] American Psychological Association (APA). (n.d.). Zarit Burden Interview. Retrieved from https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/zarit.

[74] Centers for Medicare & Medicaid Services (2018).

[75] Office of the Assistant Secretary for Planning and Evaluation. (2018). *An Overview of Long-Term Services and Supports and Medicaid: Final Report.* Retrieved from https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0.

[76] Centers for Medicare and Medicaid Services. (2020). *Long-Term Services and Supports Rebalancing Toolkit*. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.

[77] The sections in this domain focus on formal, paid care; refer to Domain 4: Referral for self-assessment on informal care.

[78] University of Illinois. (n.d.). Disability Theory: Social/Independent Living Model. Retrieved from https://guides.library.illinois.edu/c.php?g=549817&p=3774566.

[79] Ho, L., Malden, S., McGill, K., et al. (2023). Complex interventions for improving independent living and quality of life amongst community-dwelling older adults: a systematic review and meta-analysis. *Age and Ageing, 52*(7). Retrieved from https://doi.org/10.1093/ageing/afad132.

[80] Stanford Medicine. (2019). Interpreter Guidelines. Retrieved from https://geriatrics.stanford.edu/culturemed/overview/assessment/interpreters.html.

[81] See Subdomain 1.4 – Assessment for a full description of the assessment(s).

[82] See Subdomain 2.3.2 – Care Availability for more information.

[83] See Subdomain 1.3.1 – Composition for more information on the implementation of telemedicine.

[84] 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 behavioral health providers that can serve these individuals. One strategy is to contract with health plans or providers that colocate mental health services in primary care clinics or place primary care providers in mental health clinics.

[85] See Subdomain 1.3.1 – Composition for more information on the implementation of telemedicine.

[86] Seematter-Bagnoud, Laurence. (2018).

[87] Olivari, B. S., Baumgart, M., Lock, S. L., Whiting, C. G., Taylor, C. A., Iskander, J., Thorpe, P., & McGuire, L. (2018). CDC Grand Rounds: Promoting Well-Being and Independence in Older Adults. *Morbidity and Mortality Weekly Report, 67*(37), 1036–1039. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/mm6737a4.htm.

[88] Givler, D. N., & Givler, A. (2023). Health Screening. *National Library of Medicine*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK436014/.

[89] U.S. Preventive Services Task Force. (n.d.). Screening for Speech and Language Delay and Disorders in Children. Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/home.

[90] U.S. Preventive Services Task Force. (n.d.). *USPSTF: An Overview.* Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/inline-files/uspstf-overview-fact-sheet-2021.pdf.

[91] U.S. Department of Health and Human Services. (2020). *Medicare Coverage Determination Process*. Retrieved from https://www.hhs.gov/guidance/document/medicare-coverage-determination-process-0.

[92] Centers for Medicare and Medicaid Services. (2023). National Coverage Determination Process & Timeline. Retrieved from https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coverage/national-coverage-determination-process-timeline.

[93] Dolgin, J. L. (2015). Unhealthy Determinations: Controlling "Medical Necessity." *Virginia Journal of Social Policy & the Law, 22*(3), 436–490. Retrieved from https://scholarlycommons.law.hofstra.edu/faculty_scholarship/1067.

[94] Centers for Medicare and Medicaid Services. (2024). Medicare Preventive Services. Retrieved from https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

[95] Centers for Disease Control and Prevention. (2020). Preventive Services Coverage. Retrieved from https://www.cdc.gov/high-quality-care/hcp/resources/preventive-services-coverage.html.

[96] Centers for Medicare and Medicaid Services, Medicare Learning Network. (2022). *Items & Services Not Covered Under Medicaid.* Retrieved from https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/items-and-services-not-covered-under-medicare-booklet-icn906765.pdf.

[97] Kornfield, T., Kazan, M., Frieder, M., Duddy-Tenbrunsel, R., Donthi, S., & Fix, A. (2021). Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment. *Commonwealth Fund.* Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits.

[98] Dunbar, S. (2022). *In-lieu-of services and value-added benefits: implications for managed care rate* setting [Meeting transcript]. Medicaid and CHIP Payment and Access Commission. Retrieved from https://www.macpac.gov/wp-content/uploads/2022/12/12-08-22-and-12-09-22-MACPAC.Public.pdf.

[99] Centers for Medicare and Medicaid Services. (2022). Paying the right amount for drugs if you have Extra Help. Retrieved from https://www.medicare.gov/basics/costs/help/drug-costs.

[100] Centers for Medicare and Medicaid Services. (2023). State Prescription Drug Resources. Retrieved from https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/index.html.

[101] 2-1-1 provides free and confidential information and referral for help with food, housing, employment, health care, counseling, and more. More information can be found at https://www.211.org/.

[102] The National Long-Term Care Ombudsman Resource Center. (n.d.). About Ombudsman. Retrieved from https://ltcombudsman.org/about.

[103] U.S. Department of Health and Human Services. (2021). HIPAA for Professionals. Retrieved from https://www.hhs.gov/hipaa/for-professionals/index.html.

[104] U.S. Department of Health and Human Services. (2024). Information Related to Mental Health and Behavioral Health, including Opioid Overdose. Retrieved from https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html.

[105] Centers for Medicare & Medicaid Services (2018).

[106] Health Resources & Services Administration (2020).

[107] Satake, A., & McElroy, V. (2024). *Inpatient Transitions of Care: Challenges and Safety Practices.* AHRQ's Patient Safety Network. Retrieved from https://psnet.ahrq.gov/primer/inpatient-transitions-care-challenges-and-safety-practices.

[108] Earl, T., Katapodis, N., & Schneiderman, S. (2020). *Making Healthcare Safer III: A Critical Analysis of Existing and Emerging Patient Safety Practices*. Chapter 15: "Care Transitions." Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK555516/.

[109] Tyler, N., Hodkinson, A., Planner, C., Angelakis, I., Keyworth, C., Hall, A., Pascall Jones, P., Wright, O., Keers, R., Blakeman, T., & Panagioti, M. (2023). Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis. *JAMA Network Open, 6*(11). Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812390.

[110] AHRQ. (2022). Resources and Tools to Improve Discharge and Transitions of Care and Reduce Readmission. Retrieved from https://www.ahrq.gov/patient-safety/resources/improve-discharge/index.html.

[111] Pruitt, Z., Emechebe, N., Quast, T., Taylor, P., & Bryant, K. (2018). Expenditure Reductions Associated with a Social Service Referral Program. *Population Health Management*, *21*(6), 469–476. Retrieved from https://doi.org/10.1089/pop.2017.0199.

[112] Health Affairs. (2020). Addressing Social Determinants: Scaling Up Partnerships With Community-Based Organization Networks. *Health Affairs Blog*. Retrieved from https://www.healthaffairs.org/content/forefront/addressing-social-determinants-scaling-up-partnerships-community-based-organization.

[113] Partnership to Align Social Care. Website. Retrieved from https://www.partnership2asc.org/about/.

[114] For more information on Self-Directed Services, visit https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html.

[115] Fisher, R., Parmer, J. Duggleby, W., et al. (2020). Health-care Workforce Training to Effectively Support Family Caregivers of Seniors in Care. *Canadian Geriatrics Journal, 23*(2), 160–171. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7259919/.

[116] 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.

[117] Rural Health Information Hub. (2019). *Rural Transportation Toolkit: Barriers to Transportation in Rural Areas*. Retrieved from https://www.ruralhealthinfo.org/toolkits/transportation/1/barriers.

[118] National Aging and Disability Transportation Center. (n.d.). *Federal Funding for Transportation Programs Serving Older Adults and People with Disabilities – Resource Guide*. Retrieved from https://www.nadtc.org/wp-content/uploads/USAging-NADTC-Transportation-Funding-Guide-508.pdf.

[119] Centers for Medicare and Medicaid Services. (n.d.). Employment Services. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/employment-initiatives/employment-services/index.html.

[120] Centers for Medicare and Medicaid Services. (2011). *Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf.

[121] Centers for Medicare & Medicaid Services. (n.d.). Employment & HCBS. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/employment-initiatives/employment-hcbs/index.html.

[122] A PAD is a legal document that details a person's preferences for future mental health treatment or names an individual to make treatment decisions if the person is in a crisis and unable to make decisions. Excerpt from:

National Alliance on Mental Illness. (n.d.). Psychiatric Advance Directives. Retrieved from https://www.nami.org/Advocacy/Policy-Priorities/Responding-to-Crises/Psychiatric-Advance-Directives.

[123] Centers for Medicare & Medicaid Services. (n.d.). Five-Star Quality Rating System. Retrieved from https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system.

[124] 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 can serve these individuals. One strategy is to contract with health plans or providers that colocate mental health services in primary care clinics or place primary care providers in mental health clinics.

[125] A Gold Star parent is a parent of a service member who lost their life in service to the country.

[126] The National Association of State Veterans Homes. (n.d.). Healthcare & Services for Eligible US Veterans. Retrieved from https://nasvh.org/.

[127] Residential nursing homes (sometimes referred to as custodial nursing homes) will be referred to as nursing homes within this Tool.

[128] Institute for Healthcare Improvement. (n.d.). Age-Friendly Health Systems. Retrieved from https://www.ihi.org/initiatives/age-friendly-health-systems.

[129] Centers for Medicare & Medicaid Services. (2022). *CMS Framework for Health Equity 2022–2032*. Retrieved from https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.

[130] Centers for Medicare & Medicaid Services. (2018). *Guide to Reducing Disparities in Readmissions*. Retrieved from https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf.

[131] Health Resources & Services Administration. (2020). *Advancing Health Center Excellence*. Retrieved from https://bphc.hrsa.gov/sites/default/files/bphc/funding/hce-fact-sheet.pdf.

[132] National Institute on Aging. (n.d.). Health Disparities Framework. Retrieved from https://www.nia.nih.gov/research/osp/framework.

[133] Mungas, D., Reed, B. R., Crane, P. K., Haan, M. N., & González, H. (2004). Spanish and English Neuropsychological Assessment Scales (SENAS): further development and psychometric characteristics. *Psychological assessment, 16*(4), 347–359. Retrieved from https://pubmed.ncbi.nlm.nih.gov/15584794/.

[134] Teng, E. L., Hasegawa, K., Homma, A., Imai, Y., Larson, E., Graves, A., Sugimoto, K., Yamaguchi, T., Sasaki, H., & Chiu, D. (1994). The Cognitive Abilities Screening Instrument (CASI): a practical test for cross-cultural

epidemiological studies of dementia. *International psychogeriatrics, 6*(1), 45–62. Retrieved from https://doi.org/10.1017/s1041610294001602.

[135] Dick, M. B., Teng, E. L., Kempler, D., Davis, D. S., & Taussig, I. M. (2002). The Cross-Cultural Neuropsychological Test Battery (CCNB): Effects of age, education, ethnicity, and cognitive status on performance. In F. R. Ferraro (Ed.), Minority and cross-cultural aspects of neuropsychological assessment (pp. 17–41). Swets & Zeitlinger Publishers. Retrieved from https://www.academia.edu/67265734/The_Cross_Cultural_Neuropsychological_Test_Battery_CCNB_Effects_of_age_education_ethnicity_and_cognitive_status_on_performance.

[136] Gonzalez, C. M., Lypson, M. L., & Sukhera, J. (2021). Twelve Tips for Teaching Implicit Bias Recognition and Management. *Med Teach*, *43*(12), 1368–1373. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8349376/pdf/nihms-1693536.pdf.

[137] Rickert, J. (2012). Patient-Centered Care: What It Means And How To Get There. *Health Affairs Blog*. Retrieved from https://www.healthaffairs.org/content/forefront/patient-centered-care-means-and-get-there.

[138] Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013). Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health affairs (Project Hope), 32*(2), 223–231. Retrieved from https://doi.org/10.1377/hlthaff.2012.1133.

[139] Zughni, L. A., Gillespie, A. I., Hatcher, J. L., Rubin, A. D., & Giliberto, J. P. (2020). Telemedicine and the Interdisciplinary Clinic Model: During the COVID-19 Pandemic and Beyond. *Otolaryngology – Head and Neck Surgery: Official Journal of American Academy of Otolaryngology-Head and Neck Surgery, 163*(4), 673–675. Retrieved from https://doi.org/10.1177/0194599820932167.

[140] Omboni, S., Padwal, R. S., Alessa, T., Benczúr, B., Green, B. B., Hubbard, I., Kario, K., et al. (2022). The Worldwide Impact of Telemedicine During COVID-19: Current Evidence and Recommendations for the Future. *Connect Health, 1*, 7–35. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7612439/.

[141] Kim, L. D., Koncilja, K., & Nielsen, C. (2018). Medication Management in Older Adults. *Cleveland Clinic Journal of Medicine, 85*(2), 129–135. Retrieved from https://doi.org/10.3949/ccjm.85a.16109.

[142] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Substance Abuse Among Older Adults. (1998). Treatment Improvement Protocol (TIP) Series, No. 26. Chapter 5 – Referral and Treatment Approaches. Available from https://www.ncbi.nlm.nih.gov/books/NBK64409/.