

# Health Care Home Care Coordination

## Toolkit for Working with Persons with Complex Needs and Older Adults

J A N U A R Y 2 0 1 6 V E R S I O N



This toolkit was created as a part of the Medicare Multipayer Advanced Primary Care Provider (MAPCP)  
Demonstration Project August 2013



## Introduction

Welcome to the toolkit for health care home (HCH) clinics that are serving Medicare beneficiaries! The goal of this toolkit is to offer resources and guidance to certified HCH clinics caring for seniors and people with disabilities who have complex functional support needs in addition to their medical issues.

The resources and guides in this toolkit were created and selected as best practices in the field of senior and disability care. The intent is to offer clinics and individual care coordinators in multi-specialty and family practice clinics, caring for the full range of ages and conditions, efficient methods to assess and care plan for the complex population of seniors and people with disabilities. The resources and guides are intended to supplement your existing assessments, care plans, and processes with specialized tools for engaging with community-based supports and services needed within an “extended care plan.”

The toolkit is arranged topically in a checklist. The authors suggest clinics and care coordinators work through the topics as HCH policies are developed for certification and recertification, to ensure the unique needs of older adults, people with disabilities and their caregivers are addressed. Resources also may be accessed on an individual patient level as needed. One suggestion is to identify a community-based or regional partner from the aging or disability provider communities to assist you in reviewing the contents.

The intent of this toolkit is to provide an array of resources, tools, and guides for building a model of care that effectively serves persons who are seriously ill and/or disabled, including Medicare beneficiaries. We hope that all HCHs will find aspects of this toolkit useful, however, also recognize that some clinics, such as clinics specializing in geriatric health or larger health care systems, may already have processes or tools in place other than those in this toolkit.

***The workgroup intends that this web-based resource be regularly updated, and that in the future it be supplemented with additional resource, as requested by HCH teams. We want it to be responsive to your specific needs. Please check the dates on each section for the most recent update.***



### Development:

The toolkit was developed through the efforts of a formal workgroup of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. Medicare conducted the demonstration in Minnesota and seven other states. Your clinic is able to bill Medicare monthly for your care coordination services for individuals participating in Traditional Medicare. (Medicare Advantage enrollees are not currently included). More information about the demonstration

<http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/>

The MAPCP Resource Workgroup was made up of community stakeholders with geriatric and disability expertise, including geriatric physicians, advocacy groups, Area Agency on Aging and Minnesota Board on Aging representatives, Health Care Home care coordinators, consumers, and Health Department and Department of Human Services representatives.

## ■ ■ □ Disclaimer

This toolkit is intended to be a resource for health care homes. This toolkit is not intended to be an all-inclusive listing of tools and resources; as more research is conducted and services/resources are developed, this resource will likely change. While all the tools, screenings, and guides selected have been considered best practices in the field of senior and disability care, the Minnesota Department of Health does not endorse any of the specific tools in this toolkit. The intent is to offer clinics and care coordinators efficient methods to assess and care plan for the complex population of seniors and people with disabilities.



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## Care Coordination: Comprehensive Patient Assessment

The following is a checklist of elements that could be included when conducting an assessment of a person with complex medical, functional, behavioral, or cognitive needs. This list is not meant to be all-inclusive, but rather a guideline of different information that would be helpful to collect when assessing individuals. Collaborate with primary care and other care coordinators to develop an integrated patient centered care plan.

### General Information

- Identify any language or cultural barriers
- Include family decision maker and emergency contact noting they may be different persons
- Identify a family/friend caregiver (might accompany the patient to primary care visits, provide medication set up, etc.)
- Identify other care coordinators involved in patient's life/care ([See page 10 for definitions/descriptions and other care coordination and transition models](#))
- List other agencies providing service/involved in the care of the patient

### Health Assessment

- Identify other physicians involved in care
- List conditions/diagnoses
- List medications, including: OTC drugs, herbal remedies and supplements; and assess interactions ([See page 20 for links and tools](#))
- Assess cognition (For all patients over 65 perform a Mini-Cog.) ([See link on page 24 for provider best practices](#))
- Assess home/living environment ([See page 29 for links to helpful tools](#))
- Assess ability to perform Activities of Daily Living (ADLs) and Instrumental ADLs in patient's home environment
- Assess who assist with the ADLs if patient is not able to perform
- Identify need for special equipment/assistive devices
- Identify medical treatments/therapies being utilized
- Assess behavioral health, including emotional health, mental health, and substance use/misuse ([See page 27 for tools and links](#))
- Assess nutritional needs
- Identify utilization of other medical resources (frequency of hospitalizations, emergency room visits, nursing facility care)
- Assess self-preservation and safety
- Assess risk for abuse/neglect
- Assess exercise routine
- Identify hobbies and interests
- Identify any Advanced Directives in place ([See page 29 for links to optional documents](#))



## ■ ■ ■ Disability-Competent Care

It is likely that the majority of Medicare beneficiaries enrolled in your health care home will be older than 65 years of age. However, if your clinic also cares for Medicare beneficiaries under age 65, there are some newly identified resources that have been developed specifically for your consideration. These resources include tools regarding complex physical problems such as spinal cord injury and tools derived from care innovations for individuals with intellectual and developmental disabilities. Resources range from conceptual statements of a disability-competent model, through care system self-assessment tools and specific tools for assessment and care delivery. All materials integrate both medical and functional considerations.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) is developing technical assistance and actionable tools such as these based on successful innovations and care models for adults with disabilities. MMCO contracted with The Lewin Group, along with the Institute for Healthcare Improvement (IHI), to assist with these efforts. Minnesotans participated in the development of the tools and perspectives offered by this resource.

Follow this link: <https://www.resourcesforintegratedcare.com/concepts/disability-competent-care>

## Introduction

Family and informal caregivers (spouse, adult children, parents, other relatives, partners or friends) are a critical source of support for individuals with chronic or disabling conditions. Family caregivers contribute to improved continuity of care and better outcomes for those needing care. Caregivers provide valuable information on the patient's medical condition, manage medication, carry out complex treatments plans and make major medical decisions. The presence of a family caregiver can improve medical compliance, reduce the length of hospital stays, and prevent hospital readmissions, unnecessary emergency room and doctor's visits, and premature nursing facility placement. The caregiver is an important member of the health care team.

## Conversation with the Caregiver

It is important to speak directly with the caregiver about the tasks they perform and to ask them about their experience as a caregiver. They are the experts about how the patient functions in the home environment, which is valuable information for the rest of the health care team. The following guided conversation is suggested in order to increase the caregiver's confidence and capacity to assist the person they are caring for and as a means of connecting them to services and resources that can support them. It is critical to take into account the ethnic, cultural, and relationship context of the caregiver and patient.

The following questions should be asked of the caregiver after each visit.

- Do you have questions about the care recommendations?
- What are your concerns regarding their health?
- What issues would you like communicated to the doctor?
- Who helps you in providing care/assistance? Family, friends, outside services?
- What medical tasks are you being asked to do? Are you comfortable performing these tasks?
- Would you like more information or a demonstration on how to complete one or more of these tasks?

These additional questions will let the caregiver know you are looking out for their interests and will give you insight into the ability to support the patient's plan of care.

- How are things going for you?
- What are some things that are going well and appear to be working?
- What's one pleasant thing you've done for yourself today? This week?
- Are you aware of the services or resource available to help you provide care and /or support your needs as the caregiver? If yes, what services have you used? If no, would you like more information about these services and resources?

## Caregiver Services Include:

- **Caregiver Consultant/Coach-**(Caregiver Consultants are a very good resource to connect with first as they are able to provide ongoing assistance to the caregiver and can connect them to local resources. ) Consultation includes an assessment to help caregivers identify and build on their strengths in order to



find the best way to provide quality care while maintaining a healthy, balanced lifestyle. Through ongoing support the consultant helps the caregiver to set and meet goals, solve problems, manage daily challenges of caregiving and to connect to services and resources.

- **Family Meetings:** Facilitated meetings by a Caregiver Consultant for spouses, children, and others involved in the care of a family member, to help identify needs, share responsibilities, work through conflict, and develop a plan that will best serve the patient and family.
- **Caregiver Support Groups:** Group sessions that offer caregiver education, information about community resources, and emotional support and networking with other caregivers. Most groups meet in-person but groups are also available by telephone, or via the internet.
- **Caregiver Education:** Group or individual education and skills training on managing risk factors (e.g., caregiver stress and depression), caregiver role development and identity change, family dynamics, direct care skills, disease management, managing difficult behaviors, communicating with health care providers, navigating health and long-term care systems, building a support network, and financial and legal issues.
- **Adult Respite Care:** Temporary, substitute care, supervision, support, and companionship for adults to provide a recurring period of relief or rest for family caregivers. Offered at home and in community settings, ranging from hourly to short term residential stays.

<http://www.minnesotahelp.info/Public/default.aspx?se=caregiver> is a caregiver specific section that contains information on providers who offer the services listed above.

### Additional links and tools:

[Minnesota Board on Aging Caregiver](#) provides links to:

- Caregiver resource materials including MBA Caregiver Resource Guide and Booklet that provide tips and tools for new or unaware caregivers and resources for professionals and community agencies.
- MN Memory Care site
- Powerful Tools for Caregivers –information on the evidence based caregiver education including links to finding classes

The MN Choices Caregiver Module: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6914-ENG> (copy the link into your browser) is a 16-item tool used by long-term care consultants for family caregivers of individuals applying for Minnesota waivers or the Alternative Care program. It is used to identify a caregiver's needs and resources to support them.

The [MBA Title III-E Caregiver Assessment](#) is a tool used by Minnesota caregiver consultants to identify and support family caregivers. It addresses the 7 domains of caregiver assessment, includes stress/burden and depression measures, and a caregiver plan with goals.

Section 7 of the RED Toolkit , [Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge](#) Part of the Project RED Toolkit targets the family as a critical part of a successful discharge and provides information on integrating family caregivers into discharge planning.



## Determining Involvement of other Care Coordinators

### Interview Questions to Assist with the Identification of Other Care Coordination Involvement

1. Who else is involved with your care?
2. Do you have someone who regularly helps you?
3. Do you have someone who comes to your home to help you?
4. Do you pay for assistance you are getting at home?
5. Is there someone you call that helps you arrange for care?

Note: HCH Clinic Coordinator may be able to determine if this client has another care coordinator by consulting the billing department regarding the client's current Medical Assistance/Waiver enrollment

## ■ ■ □ Care Coordinator Identification Table

HCH requirement 4764.0000 Subp.8 requires HCH Clinics to integrate with external care plans. The following list may not be all inclusive but provides some possible sources for determining who may be the other Care Coordinators involved with the consumer.

Title	Possible Program/Health Provider Funding this Role	Roles and Responsibilities of this Title	System used to Locate the Care Coordinator Assigned
Care Coordinator, Care Manager, Case Manager, Service Coordinator	Alternative Care(AC), Brain Injury(BI),* Community Alternatives for Disabled Individuals (CADI),* Elderly Waiver (EW),* Minnesota Senior Health Options (MSHO),* Special Needs Basic Care(SNBC) *these services require the patient to be on Medical Assistance	Care Coordination means the assignment of an individual who coordinates the provision of all health and long-term care services for an older adult. This includes health, social service, and community support service professionals across settings of care. This individual might be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.	MNIts (Minnesota Information Technology System), Health Plan, Care System
Care Manager (also known as Geriatric Care Manager)	Private Pay Examples of agencies that provide this service: DARTS, Volunteers of America, Pathfinders,	Professional staff (RN or SW) who provide: <ul style="list-style-type: none"> <li>• Comprehensive assessment of an older adult's situation</li> <li>• A plan of care developed in collaboration with the older adult, family members and health care providers</li> </ul>	Contact the agency that is providing this service

Title	Possible Program/Health Provider Funding this Role	Roles and Responsibilities of this Title	System used to Locate the Care Coordinator Assigned
	Jewish Family Services,	<ul style="list-style-type: none"> <li>• Monitoring of the plan on an ongoing basis with phone calls and visits to ensure that needs are being met</li> <li>• Communication with out-of-town family members to keep them apprised</li> <li>• Advocate with healthcare providers on behalf of the older adult, including accompanying the older adult to his/her appointments</li> </ul>	
Care Navigator	Private Health Insurers or Health Systems. May be tied to a specific disease process eg. Breast cancer, Chronic Pain	A professional with a health or social care background that coaches individuals with Long Term Care needs to achieve personal goals that have a positive impact on maintaining or improving their health and/or well-being. This includes brokering innovative solutions across health, social, and community services.	Client's insurance or Health Plan
Targeted Case Manager	Medical Assistance	Targeted Case Management services assists an adult with mental health challenges in identifying the individual's goals, strengths and needs; plans with the individuals what services and community resources might help to accomplish the individuals goals; helps refer (and often accompany) the individual to obtain services and resources; and then monitors and coordinates with those services and resources to assure that the individual is getting the help needed to accomplish the individual's goal and to address individual needs.	MNits, MMIS
Caregiver Consultant	Title III Funding which comes from the Federal	An individual support service <i>provided by a trained professional</i> that equips caregivers with the knowledge,	Area Agencies on Aging

Title	Possible Program/Health Provider Funding this Role	Roles and Responsibilities of this Title	System used to Locate the Care Coordinator Assigned
	Older Americans Act.	<p>skills and tools to <i>develop themselves and</i> perform their caregiver role.</p> <p>The caregiver coach/consultant service includes a comprehensive caregiver assessment to identify the caregiver's needs and values related to their caregiving role, and development of a customized plan that includes goal setting, and problem solving, coaching, and ongoing support to reach established goals. Support may be provided as education, skills development including self-advocacy, coping and disease management; coaching skills such as cognitive reframing, crisis management, problem solving, family meetings and resource information.</p>	
Heath Care Home(HCH) Care Coordinator, Community Coordinator, Transition Planner	Certified Health Care Homes	An employee of the primary care clinic who works with the consumer, family, and physician in providing family centered care. The care coordinator encourages the consumer to take an active role in managing their health care by helping to identify and address barriers to comprehensive health care. This includes coordination of care across settings (acute, primary, and long term care) and linking the consumer and family to community resources and social services.	The clinic where the consumer receives their primary care.
Community Living Specialist	Area Agencies on Aging through the Minnesota Board on Aging	A licensed Social Worker or Registered Nurse with a Baccalaureate Degree who assists consumers who are not on Medical Assistance who are currently residing in a nursing facility with transitioning from nursing facility care back into community living, working with the consumers,	Senior LinkAge Line®

Title	Possible Program/Health Provider Funding this Role	Roles and Responsibilities of this Title	System used to Locate the Care Coordinator Assigned
		their family, the nursing facility, physician, and community supports to develop a person-centered care transition plan.	
Live Well at Home Provider	Area Agencies on Aging and other providers working with the Live Well At Home Project	<p>The Live Well at Home Provider uses the LWAH Rapid Screen to:</p> <ul style="list-style-type: none"> <li>• Identify an older adult’s personal risks that could cause them to move from their home.</li> <li>• Assess older adult’s needs and community living goals.</li> <li>• Provide education, counseling and coordination support for “risk factors” identified.</li> <li>• Connect the older adult to other service providers, volunteers, and resources that will help them to achieve their goals for living at home.</li> <li>• Assist the older adult to plan for and purchase help early on to live at home, using their own funds.</li> </ul>	Area Agencies on Aging
Support Planner (Previously known as a Flexible Case Manager)	Alternative Care Brain Injury Community Alternatives for Disabled Individuals, Elderly Waiver Minnesota Senior Health Options	<p>Support planning services use a person-centered approach helping the person to develop and implement a self-directed service and support plan. Components may include:</p> <ul style="list-style-type: none"> <li>• Helping people to select, employ, train, and schedule their own direct care workers</li> <li>• Defining worker responsibilities and tasks</li> <li>• Evaluating and monitoring results</li> </ul>	This is generally considered a service under many of the public programs. Checking MNIts and/or connecting with the consumer’s Health Plan can assist with identifying who this person might be.

Title	Possible Program/Health Provider Funding this Role	Roles and Responsibilities of this Title	System used to Locate the Care Coordinator Assigned
		<ul style="list-style-type: none"> <li>• Creating and modifying the person’s individual plan and budget</li> <li>• Advocating and problem solving</li> <li>• Coordinating service delivery</li> <li>• Arranging for other services as needed for the person to remain at home</li> </ul>	
Alzheimer’s Association Care Consultant	Alzheimer’s Association	<p>Individualized assistance, problem solving and identification of resources are available to persons with memory loss and their family. Care Consultations (both phone and in-person) include:</p> <ul style="list-style-type: none"> <li>• Identifying your current needs</li> <li>• Assistance with developing a plan</li> <li>• Assistance with finding resources and services</li> <li>• Problem-solving</li> <li>• Providing education and support</li> <li>• Providing ongoing support and follow-up</li> </ul>	Call the Alzheimer’s Association 24/7 Information Helpline at 1.800.272.3900 and request a care consultation today

## Evidenced-Based Care Transition Models

Effective transitional care is crucial in providing effective health care for persons and for reducing avoidable hospital readmissions. Several care transition models, which have been supported by research and evaluation, are described in the table below ([Aging and Disability Resource Center, Technical Assistance Exchange, 2013, http://www.adrc-tae.acl.gov/tiki-index.php?page=EvidencebasedCTModels](#)):

The Care Transitions Program®	The Transitional Care Model	Better Outcomes for Older Adults through Safe Transitions (BOOST)	The Bridge Model	Guided Care®	Geriatric Resources for Assessment of and Care of Elders (GRACE)
<p>(Coleman, no date [n.d.], <a href="http://www.caretransitions.org">www.caretransitions.org</a>)</p> <p>Transition Coach helps patients and families learn transition-specific self-management by:</p> <ul style="list-style-type: none"> <li>• Conducting a hospital visit to introduce the program and tools such as the Personal Health Record (PHR)</li> <li>• Conducting one home visit 24-72 hours post-discharge:</li> </ul>	<p>(Naylor &amp; Ware, 2009, <a href="http://www.transitionalcare.info">www.transitionalcare.info</a>)</p> <p>The Transitional Care nurse:</p> <ul style="list-style-type: none"> <li>• Visits patient in the hospital to:               <ol style="list-style-type: none"> <li>1. Conduct an in-hospital assessment (+ functional status)</li> <li>2. Collaborate with care-team members to reduce</li> </ol> </li> </ul>	<p>(2008, <a href="http://www.hospitalmedicine.org/BOOST">www.hospitalmedicine.org/BOOST</a>)</p> <p>BOOST includes specific interventions to mitigate high risk patients' risks for adverse events:</p> <ul style="list-style-type: none"> <li>• A standardized discharge process</li> <li>• Efforts to improve patient/caregiver preparedness</li> <li>• Medication safety</li> <li>• Follow-up care</li> <li>• Tool for Addressing Risk: a Geriatric</li> </ul>	<p>(Illinois Transitional Care Consortium, n.d., <a href="http://www.transitionalcare.org">www.transitionalcare.org</a>)</p> <p>A hospital-based social work model designed for older adults discharged home from an inpatient hospital stay to safely transition back to the community by providing:</p> <ul style="list-style-type: none"> <li>• Intensive care coordination that starts in the hospital and continues after discharge to the community</li> <li>• Aging Resource</li> </ul>	<p>(Johns Hopkins University, 2013, <a href="http://www.guidedcare.org">www.guidedcare.org</a>)</p> <p>Program requires that Guided Care Nurse:</p> <ul style="list-style-type: none"> <li>• Conduct a comprehensive home assessment</li> <li>• Create a care guide and an action plan for the patient</li> <li>• Provide monthly monitoring and self-management coaching</li> <li>• Smooth transitions</li> </ul>	<p>(Indiana University, 2011, <a href="http://medicine.iupui.edu/iucar/research/grace/">http://medicine.iupui.edu/iucar/research/grace/</a>)</p> <p>Program requires that nurse practitioner and social worker:</p> <ul style="list-style-type: none"> <li>• Offer in-home assessment and care management</li> <li>• Collaborate with and support the primary care physician</li> <li>• Meet with the patient's primary</li> </ul>



The Care Transitions Program®	The Transitional Care Model	Better Outcomes for Older Adults through Safe Transitions (BOOST)	The Bridge Model	Guided Care®	Geriatric Resources for Assessment of and Care of Elders (GRACE)
<ol style="list-style-type: none"> <li>1. Actively engages patients in medication management; helps them develop a clear, easily understandable medication regimen and enter into PHR</li> <li>2. Uses role-playing and other tools to teach skills to patients and family members on how to communicate needs with health care professionals</li> <li>3. Reviews any “red flags” that indicate a worsening condition, and</li> </ol>	<p>adverse events and prevent functional decline</p> <ol style="list-style-type: none"> <li>3. Develop a streamlined, evidence-based plan of care</li> </ol> <ul style="list-style-type: none"> <li>• Conducts home visit within 24 hours of discharge to assess safety in completing Activities of Daily Living and Instrumental Activities of Daily Living, and recommend environmental adaptations and refer to other services</li> </ul>	<p>Evaluation for Transitions (TARGET) is a 4-part tool that includes:</p> <ol style="list-style-type: none"> <li>1. Risk stratification process using eight elements</li> <li>2. Risk-specific intervention plan linked to the 8P risk score summary</li> <li>3. Universal set of expectations for all patients being discharged from the hospital to home (the Universal Checklist)</li> <li>4. General Assessment of Preparedness (GAP), a component list of</li> </ol>	<p>Centers (ARC) inside hospitals that provide a dedicated space for older adults and their caregivers to explore community resources, health information and caregiving materials, and to develop community care plans before discharge.</p> <ul style="list-style-type: none"> <li>• Pre-discharge: Bridge Care Coordinators (BCCs) identify older adult patients who may be at risk for post-discharge complications and meet with them and/or their caregivers to identify unmet needs and set up</li> </ul>	<p>into and out of hospitals and other institutions</p> <ul style="list-style-type: none"> <li>• Coordinate care by all providers</li> <li>• Provide family caregiver education/support</li> <li>• Facilitate access to community based services</li> </ul>	<p>care physician to review, modify and prioritize the care plan, then collaborate with the physician</p> <ul style="list-style-type: none"> <li>• Work weekly with geriatrician-led interdisciplinary team to craft patient care plan</li> <li>• Conduct at least one in-home follow-up visit to review care plan, and one telephone or face-to-face contact per month</li> <li>• Coordinate care from all providers</li> <li>• Collaborate with hospital discharge planners and make a home visit after</li> </ul>

The Care Transitions Program®	The Transitional Care Model	Better Outcomes for Older Adults through Safe Transitions (BOOST)	The Bridge Model	Guided Care®	Geriatric Resources for Assessment of and Care of Elders (GRACE)
<p>response strategies</p> <ul style="list-style-type: none"> <li>• Making three follow up phone calls focused on reviewing the progress toward established goals, reinforcing the importance of maintaining PHR, and supporting the patient's self-management</li> </ul>	<ul style="list-style-type: none"> <li>• Accompanies patient on first visit with the physician post-discharge and subsequent visits if needed</li> <li>• Facilitates physician-nurse collaboration across care episodes</li> <li>• Conducts weekly home visits for first month</li> <li>• Makes telephone contact for each week that in-person visit is not scheduled</li> <li>• Is on call seven days per week for home visits and telephone access</li> </ul>	<p>issues important to providers and patients (and their caregivers) surrounding the readiness of patients for transition out of hospital</p>	<p>services prior to discharge. BCCs also prepare for discharge by reviewing medical records or meeting with an interdisciplinary team within the hospital.</p> <ul style="list-style-type: none"> <li>• Post-discharge: BCCs call consumers 2 days after discharge to conduct a secondary assessment and intervene on identified needs, including understanding discharge instructions, transportation issues, physician follow-up, burdened caregivers, problems with home health</li> </ul>		<p>any hospitalization</p>

The Care Transitions Program®	The Transitional Care Model	Better Outcomes for Older Adults through Safe Transitions (BOOST)	The Bridge Model	Guided Care®	Geriatric Resources for Assessment of and Care of Elders (GRACE)
	<ul style="list-style-type: none"> <li>• Provides active engagement of patients and family caregivers with focus on goals</li> <li>• Provides communication to, between, and among the patient, family caregivers, and health care providers</li> </ul>		<p>care, difficulty obtaining and/or understanding medications.</p> <ul style="list-style-type: none"> <li>• Follow-up: The BCC follows up with consumers at 30 days post-discharge to track their progress and address needs</li> </ul>		



## Medication Management

### Best Practices/Strategies for Improvement of Medication Management

Taken from *Reducing Avoidable Readmissions Effective (RARE) Campaign*

(<http://www.rareadmissions.org/areas/medmanagement.html>)

#### Best Practices

- Assess patient's and/or caregiver knowledge of medications on admission, using Teach Back and communicate this information with other health professional care providers and include in the care plan. Information from the assessment is put into the care plan and action is taken to resolve issues
- Reconcile medications on admission with input from patient and family
- Medications ordered for patient during hospitalization are compared to the medication list obtained on admission to assure chronic medications are given during hospitalization
- Discrepancies such as omission, duplications, adjustments, deletions, additions are resolved during the hospitalization
- On transition the patient's most current reconciled medication list is provided to the next care provider
- On transition, the sending organization informs the next provider how to obtain medication clarification
- The patient receives comprehensive medication education and patient level of understanding is assessed through teach back
- A written listing of medications is provided to the patient and caregiver/family upon transition including the name of the medication, the dose, the route, the purpose, side effects and special considerations in language that is easy to understand for the patient
- For patients with complicated medication regimes, pharmacy may perform patient education, medication review, follow-up phone calls, in-home visits
- For patients with complex medications refer for Medication Therapy Management and have available both in the in-patient and outpatient setting

#### Medication Reconciliation

[Improving Care Transitions: Optimizing Medication Reconciliation](#). This white paper describes common barriers to the implementation of medication reconciliation and presents foundational concepts important to its adoption. It outlines how pharmacists can contribute to improving this process using a standardized framework of service delivery. Produced by the American Pharmacists Association (APhA) and the American Society of Health System Pharmacists (ASHP). (20-page PDF).

<http://www.caretransitions.org/getdocmdt.asp> Eric Coleman, MD, director of the care transitions program at the University of Colorado in Denver, introduces the Medication Discrepancy Tool to characterize transition-related medication problems. He outlines patient-level contributing factors and system-level contributing factors. (5-page PDF)

[Medications at Transitions and Clinical Handoffs \(MATCH\) Toolkit for Medication Reconciliation](#). This toolkit is based on the MATCH website developed by Northwestern Memorial Hospital in Chicago, Illinois, through the support of AHRQ and collaboration between Northwestern University Feinberg School of Medicine and The

Joint Commission. It incorporates the experiences and lessons learned by health care facilities that have implemented the MATCH strategies to improve their medication reconciliation processes.

## ■ ■ □ Medication Management and Poly-Pharmacy: Beers Criteria

The Beers criteria are used as a national guideline and reference guide for pharmacists and physicians to improve the use of medication in the elderly. For several years, gerontologist Mark H. Beers, MD, has been advocating the use of explicit criteria-developed through consensus panels-for identifying inappropriate use of medications.

In a 1991 paper that looked at the nursing facility population, he wrote with colleagues that these explicit criteria were "based on the risk-benefit definition of appropriateness, i.e., that the use of a medication is appropriate if its use has potential benefits that outweigh potential risks." His first set of criteria was developed specifically with the frail elderly nursing facility resident in mind.<sup>1</sup>

In 1997, Beers updated his criteria to include medication therapy inappropriate in all patients over 65 years old. Consultant pharmacists can use both sets of criteria in prescription processing and drug regimen review to improve the pharmacotherapeutic regimens of their elderly patients.<sup>2</sup>

Then in 2012, the American Geriatric Society updated the Beers Criteria list based on evidence-based recommendations.<sup>3</sup>

**Link to Beers Criteria:** <http://www.dcri.org/trial-participation/the-beers-list/>

The important question to ask is what can facilities do with this information in managing medication use in the elderly? Below is a list of recommendation standards:

- Make sure your consultant pharmacist has the lists.
- Mail the lists to the medical director and attending physicians with a cover letter stating the lists are used as a national guideline and reference guide for pharmacists and physicians to improve the use of medication in the elderly. Ask if there are any new systems or procedures they would like to see at the facility.
- Set a standard that the pharmacist must address these drugs during drug regimen review.
- The dispensing pharmacy reviews Table 1 list of drugs and discuss procedurally how the dispensing of these drugs could be handled on a case by case basis.
- In-service for licensed staff and CMA's on the two tables, especially table 2.

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<sup>1</sup> Beers, M.H., Ouslander, J.G., Rollinger, I., et al. (1991). Explicit criteria for determining inappropriate medication use in nursing home residents. *Arch Intern Med*, 151: 1825–1832.

<sup>2</sup> Beers, M.H. (1997). Explicit criteria for determining potentially inappropriate medication use by the elderly: an update. *Arch Intern Med*, 157: 1531-6.

<sup>3</sup> American Geriatrics Society 2012 Beers Criteria Update Expert Panel (2012). American Geriatrics Society updated Beers Criteria for inappropriate medication use in older adults. Retrieved from [http://www.americangeriatrics.org/files/documents/beers/2012BeersCriteria\\_JAGS.pdf](http://www.americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf).

## ■ ■ □ Medicare Medication Therapy Management

**Medication therapy management (MTM)** is a distinct service or group of services that optimizes drug therapy with the intent of improved therapeutic outcomes for individual patients. Medication therapy management includes a broad range of professional activities, including but not limited to performing patient assessment and/or a comprehensive medication review, formulating a medication treatment plan, monitoring efficacy and safety of medication therapy, enhancing medication adherence through patient empowerment and education and documenting and communicating MTM services to prescribers in order to maintain comprehensive patient care.

All Medicare Part D plans offer MTM to Medicare beneficiaries. There is a great deal of variation among plans, but patients with multiple chronic conditions are likely candidates.

Medication therapy management includes five core components:

1. A medication therapy review (MTR). A MTR is a systematic process of collecting patient and medication-related information which occurs during the pharmacist-patient encounter. In addition, the MTR assists in the identification and prioritization of medication-related problems. During the MTM encounter, the pharmacist develops a Personal Medication Record (PMR) for use by the patient.
2. Personal medication record (PMR). The PMR includes all prescription and nonprescription products and requires updating as necessary. After assessing and identifying medication-related problems, the pharmacist develops a patient-specific Medication Related Action Plan (MAP).
3. Medication Related Action Plan (MAP). The MAP is a list of self-management actions necessary to achieve the patient's specific health goals. In addition, the patient and pharmacist utilize the MAP to record actions and track progress towards health goals.
4. Intervention and/or referral, and documentation and follow-up. During the MTM session, the pharmacist identifies medication-related problem(s) and determines appropriate intervention(s) for resolution. Often, the pharmacist collaborates with other health care professionals to resolve the identified problem(s). Following the patient encounter and/or intervention, the pharmacist must document his/her encounter and determine appropriate patient follow-up.

HCH clinics/care coordinators can locate MTM providers through the patient's health plan or check with local or internal pharmacies.





## ■ ■ □ Cognitive Assessments (Mini-Cog & Family Questionnaire)

### Mini-Cog

#### Instructions for Administration of the Mini-Cog and Scoring

[http://www.alz.org/documents\\_custom/minicog.pdf](http://www.alz.org/documents_custom/minicog.pdf)

The Mini-Cog is a 5 point cognitive screen that incorporates three word verbal recall and a clock draw. The Mini-Cog asks the person to remember three words. Immediately following the presentation of the words, the person is asked to draw the face of a clock and set the hands at ten past eleven. After they draw the clock, the person is asked to recall the three words.

One point is awarded for each word recalled without assistance. The person receives two points if every number on the clock is present and evenly spaced and the hands are positioned at the 11 and 2 positions. No points are awarded if either hand is set incorrectly or if numbers are missing, duplicated, or clearly spaced unevenly.

Studies have shown that the word choice may increase the sensitivity of the screen with the most sensitive word combination being “leader, season, table”. In addition, the clock draw is particularly more sensitive when staff uses phrasing that is purposively abstract by instructing the person to set the time to “10 past 11” as opposed to saying “eleven ten”. For scoring purposes, the length of the hands does not matter and full credit should be awarded even if the hand pointing to the 2 is shortest (assuming accuracy with number placement).

**Mini-Cog Scoring:** 4-5 pass; 0-3 fail

#### Assessing Cognition Using the Mini-Cog

[http://www.youtube.com/watch?v=5DS\\_FVXsdHY&feature=share&list=UUkGrLDa-K4qd7MxA-kE5g](http://www.youtube.com/watch?v=5DS_FVXsdHY&feature=share&list=UUkGrLDa-K4qd7MxA-kE5g)

### Family Questionnaire

#### Family Questionnaire and Scoring

[http://www.alz.org/mnnd/documents/family\\_questionnaire.pdf](http://www.alz.org/mnnd/documents/family_questionnaire.pdf)

If a family member is accompanying the person, staff may want to ask for their input as well. The National Chronic Care Consortium and the Alzheimer’s Association’s Family Questionnaire is a tool that can be used to obtain the family members insight on a person’s cognitive functioning. The questionnaire asks six questions of family members who have regular contact with the person.

**Family Questionnaire Scoring:** Not at all = 0; Sometimes = 1; Frequently = 2

A score greater than 3 suggests the need for additional evaluation.

**If the Mini-Cog or Family Questionnaire indicates that the person may have memory loss, refer the client to their primary care physician or a specialist (e.g., neurologist, geriatric psychiatrist, and geriatrician) to do a complete memory loss workup.**





## Home Inventory / Assessment

### Home Inventory / Assessment Description

For patients undergoing transitions, one task is a home assessment to determine whether the physical environment is safe, especially for a senior in care transitions; what changes may need to be made to the physical environment to accommodate changing physical limitations; and who could make those changes.

Encourage patients to ask themselves the following questions when considering whether services should be brought into the home or whether a housing move is necessary:

- Does my current housing situation meet my needs in terms of access, safety, security, maintenance, self-care or financial issues?
- If I stay in my home, what kinds of services would help to maintain my independence? Would I need a homemaker to provide cleaning and laundry; a home health aide to assist with personal care; a nurse to set up medications; meals-on-wheels delivered daily; an emergency response system in case of emergency; or someone to visit for companionship?
- Do I want to move to a housing setting where I can continue to live in the same place if my health needs change?
- Am I physically able to remain in my own home?
- Can adaptations be made to my home to ensure access and safety, such as adding ramps or railings?

### Resources for Safety Assessment of the Home / Home Modifications

1. *Homemods* offers training and education opportunities for professionals who wish to respond to the increasing demand for home modification services. It also serves as an information clearinghouse on home modification to equip professionals and consumers with a comprehensive inventory of resources such as a National Directory of Home Modification and Repair Resources. <http://www.homemods.org/>
2. Senior Home Safety Assessment: <http://www.eldercareteam.com/public/390.cfm> (“Print out a copy of the Home Safety Checklist and take a walk around your parents' home. Make notes of anything that could be fixed, moved, repaired or improved. Make the changes you've noted as soon as you can. Every improvement or repair will make a senior you care about just that much safer.”)

A local listing of companies that provide assessments and applications of home modifications can be found by searching with the key words of Home Modification Consultation or Certified Aging in Place Specialist at <http://minnesotahelp.info/public>.

### Falls Prevention Resources

#### Minnesota Falls Prevention Website

The MN Falls Prevention website contains tips and suggestions to prevent falls among adults. The website also includes fall prevention resources for any professional that works with adults, including information on

assessments, risk factors and interventions.

<http://www.mnfallsprevention.org>

STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Health Care Providers

<http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html>

MN Hospital Association Road Map to a Comprehensive Falls Prevention Program

<http://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/falls-prevention-roadmap.pdf>

## ■ ■ □ Prevention, Education, and Community Programs

### Healthy Aging MN Website

The Healthy Aging MN website contains information on evidence-based health promotion community classes, including a calendar listing when these classes are offered.

<http://www.mnhealthyaging.org>

### Go4Life Exercise and Physical Activity Campaign

<http://go4life.nia.nih.gov/>

### Videos on Fall Prevention

*Anyone Can Fall* available at:

<http://www.echominnesota.org/library/anyone-can-fall>

*The Good News About Fall Prevention* available at:

<http://www.spu.edu/depts/health-sciences/undergrad/videos/fall-prevention/>

NIHSeniorHealth.gov Videos - *Falls and Older Adults* available at:

<http://nihseniorhealth.gov/videolist.html#falls>



## Emotional / Mental Health

### Depression Screening Tools

#### PHQ 9

The PHQ 9 is the Minnesota Community Measurement tool recommended for Health Care Homes to assist professionals with assessing patients for depression.

<http://www.agencymeddirectors.wa.gov/Files/depressooverview.pdf>

#### Cornell University Depression Scale

[http://www.amda.com/resources/2005\\_updates\\_ltc\\_teaching\\_kits/dementia.pdf](http://www.amda.com/resources/2005_updates_ltc_teaching_kits/dementia.pdf)

#### Geriatric Depression Scale

This scale was developed as a basic screening measure for depression in older adults.

<http://www.stanford.edu/~yesavage/GDS.html>

### Suicide Risk Screening and Resources

#### Assessing Suicide Risk

Is the patient demonstrating or complaining of signs and symptoms related to depression?

- Hopelessness
- Hypersomnia
- Insomnia
- Panic Attacks
- Diminished Interest
- Psychomotor Agitation
- Anxiety
- Impaired Concentration

Assess for High Risk Factors:

- Has the patient ever attempted suicide before? If yes, what happened?
- Does the patient have a family history of suicide?
- Does the patient have a specific plan for suicide? If so, what is the plan?
- What is the method? How lethal is the method?
- Is the method available to the patient? (e.g., stockpile of pills, possession of a firearm/knife)
- Have there been recent stressors in the patient's life? (e.g., health problems, recent retirement/job loss)

- Does the patient have a history of depression? Drug/Substance Abuse? Other psychological disorders?
- Does the patient have thoughts of harming others?
- Is the patient male, over 65 years of age, widowed or divorced, and living alone? (factors that increase risk)

## National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline is a resource for both persons experiencing suicidal thoughts and providers who may be working with those persons

- 1-800-273-TALK (8255)
- The Lifeline is available 24 hours a day, seven days a week  
<http://www.suicidepreventionlifeline.org/>.

## QPR (Question, Persuade, Refer) Institute

- Offers comprehensive suicide prevention training programs, educational and clinical materials for the general public, professionals, and institutions
- Evidence-based “Gatekeeper” Model, a training to learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help  
<http://www.qprinstitute.com/index.html>

## Other Mental Health Resources

The National Alliance on Mental Health (NAMI) of Minnesota has done extensive work on services offered throughout the state from insurance coverage to housing information and treatment options. Reference NAMI’s booklet, Hope for Recovery, for a description of many mental health services and important contact information.

[NAMI Hope For Recovery Booklet](#)

## Mental Health Crisis Lines and Resources

Every county in Minnesota has a 24-hour mental health crisis hotline and many have mobile crisis units. See the links below to read the Mental Health Crisis Planning booklet and for a list of the county crisis numbers.

[NAMI Minnesota - Mental Health Crisis Planning](#)

[Minnesota Crisis Hotline Numbers by County](#)

## Senior Mental Health Services

Multiple mental health services throughout the state treat and help individuals with mental illness, but very few are dedicated specifically to seniors. Below are a few links to mental health programs in Minnesota specifically targeted and designed for individuals 55 years or older.

[Center for Senior Behavioral Health at Meeker Memorial](#) – Litchfield, MN

[Volunteers of America-Minnesota's Senior Mental Health Services](#) – Golden Valley, Coon Rapids, Minneapolis, St. Paul

[Senior Mental Health Services Brochure - VOA](#)

## Chemical Use/Dependency Background and Recovery Programs

Chemical use and dependency for individuals with mental illness is a common occurrence. Recent scientific studies, according to NAMI, suggest that close to one-third of people with all mental illnesses and one-half of people with severe mental illnesses experience substance abuse. The growing relationship between mental illness and substance abuse only worsens an individual's mental health prognosis. Below is a description of this relationship and a few recovery programs in Minnesota dedicated to the treatment of seniors.

[Substance Abuse and Mental Illness - NAMI](#)

[Senior Recovery Center](#) – St. Paul, MN: specializes in alcoholism/addiction treatment of seniors (50+) on an outpatient basis

[The Retreat](#) - Wayzata, MN: recovery day program for older adults (60+)

## Cultural Mental Health Resources

With the growing diversity in Minnesota there is a greater need for services targeting these unique cultural communities. Below are links to a list of statewide and metro organizations that provide mental health services to these cultural communities.

[Health Resources Directory for Diverse Cultural Communities](#) - Statewide

Southeast Asian Mental Health Services - Metro

<https://www.wilder.org/Programs-Services/Southeast-Asian-Services/Pages/default.aspx>

Somali & East African Behavioral Health Services Program - Metro

<http://www.voamnwi.org/somali-east-african-behavioral-health>

Latino Mental Health Services and Disparities – Metro

[Mental Health Disparities-Latino Fact Sheet](#)

## Mental Health Medication

Individuals with mental illness are on a variety of medications specific to their diagnosis. Each medication has a purpose and can affect people differently. Medication is used to treat the symptoms of mental disorders, but does not to cure it. Below is a great synopsis of common medications that treat a couple of the most common mental disorders.

## [Common Mental Health Medications](#)

## Spiritual Assessments

Spirituality can play a huge role in someone's life and may be used to cope with illness. The tool below was developed to incorporate open-ended questions regarding spirituality into a standard comprehensive history. It is a great resource that can help identify the importance of spirituality for patients.

### [FICA Spiritual History Tool](#)

## Managing Money

Managing money can be a problem for many individuals, but the addition of a mental illness can make financial situations even more difficult. With large medical bills and limited income, being careful with money management is a challenge. It is important to develop a spending plan and budget, to get help from a financial counselor and create a savings plan. There are services around the state that offer free financial counseling including ones at Lutheran Social Services.

### [Mental Health America - Managing your Money](#)

### [Lutheran Social Services MN Financial Counseling](#)

## Conservatorship and Guardianship in Minnesota

[http://www.mncourts.gov/forms/public/forms/Guardianship\\_Conservatorship/Guardianship\\_Manual/GAC101.pdf](http://www.mncourts.gov/forms/public/forms/Guardianship_Conservatorship/Guardianship_Manual/GAC101.pdf)

## Other Resources

National Alliance on Mental Illness (NAMI)

<http://www.namihelps.org/>

Ombudsman for Mental Health and Developmental Disabilities

<http://mn.gov/omhdd/>

DHS Mental Health

<http://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/>

Mental Health Association of Minnesota – Community Resources

<http://www.mentalhealthmn.org/find-support/resource-list>



## Advanced Care Planning

### Minnesota Network of Hospice and Palliative Care (Honoring Choices, Advanced Care Directives)

A Health Care Directive is a document in which a person states their wishes and preferences about health care treatment decisions- who should make them for the individuals and how the person wants those decisions made. A Health Care Directive is a plan-it is intended to guide treatment decisions in the event the person can no longer make those decisions for themselves.

There are many different health care directive forms available that meet the legal requirements in Minnesota. It is not necessary to have an attorney provide or fill out the form.

Advanced Care Planning is a Minnesota Community Measurement requirement for Certified Health Care Homes.

### Palliative Care

Palliative care (pronounced pal-lee-uh-tiv) is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness-whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. (from Center to Advance Palliative Care). To access consumer-based information on palliative care, go to the Center to Advance Palliative Care at <http://getpalliativecare.org/>.

For local resources, go to the Minnesota Network of Hospice & Palliative Care (MNHPC), whose mission is to promote quality of life in our communities through advance care planning, palliative care and hospice.

Here is the link to the MNHPC website page about palliative care: <http://www.mnhpc.org/palliative-care/>

### Minnesota Physician Orders for Life Sustaining Treatment (POLST)

The Minnesota Provider Order for Life Sustaining Treatment is a medical order, signed by a physician, nurse practitioner or physician assistant based upon a patient's preferences (directly or through a written document or proxy) for care in a life threatening emergency or at the end of life. It is based upon a national model and can be downloaded from the following site.

<http://www.mnhpc.org/advance-care-planning/learn-about-polst/>



## Expanded Care Plan

The Multi-Payer Advanced Primary Care Practice Demonstration was a clinic based initiative in Minnesota and seven other states. One of the workgroups created as a part of this initiative was the MAPCP Resources Workgroup. That workgroup of community stakeholders with geriatric and disability expertise, including geriatric physicians, advocacy groups, Area Agency on Aging and Minnesota Board on Aging representatives, Health Care Home care coordinators, consumers, and Health Department and Department of Human Services representatives. They identified areas in which to provide supplemental information for Certified Health Care Homes and care coordinators. The intent is to use this list as a guide when developing extended care plans that engage community-based supports to meet the needs of the complex population of seniors and persons with disabilities being served. To that end the following areas are encouraged to be included and addressed in an extended and person centered care plan.

- Caregiver involvement and supports for the caregiver
- Education and community-based supports for patients with memory loss and their caregiver
- Plans to address concerns identified in the home/living environment
- Referrals and follow up with patients who present with depression and/or other mental health concerns
- Inclusion of a completed “advanced health care directive” or documentation of that discussion
- Identification of the community-based supports suggested and those accepted by the patient





## Referrals to Community Supports and Resources

### Description of the Area Agencies on Aging

Minnesota's seven Area Agencies on Aging (AAA) are focal points around which older adults; the communities in which they live; and the public, healthcare, nonprofit and private organizations that support them come together to foster positive aging. Minnesota's Area Agencies on Aging provide critical support to individuals as they transition across care settings or from one home to another. AAAs and their networks of service providers have extensive experience developing and delivering community-based services. Our agencies provide an easy to navigate portal to publicly subsidized, private, and voluntary service networks. The Area Agency and its network of service providers offer access to:

- Home-delivered meals and grocery delivery to support adequate nutrition.
- Medication management services and assistance with Medicare Part D or other prescription drug payment issues to help older adults meet the challenges of medication compliance.
- Transportation services to ensure follow-up with the physician.
- Chore help, homemaker services, and home modifications to create a home environment essential to aid recovery and maintain health.
- Evidence-based health promotion and disease management programs to improve self-management and avoid hospitalization.
- Respite services and coaching for family caregivers to support them as they give hands-on care for loved-ones.

Minnesota's Area Agencies are ready and waiting to be tapped in local and statewide efforts to address these issues. Their extensive aging-related expertise and deep community connections make Area Agencies on Aging ideal partners for health care and social services organizations, including public agencies, nonprofits and others that want to help older adults live well.

Contact your local [Area Agency on Aging](#) for more information or to start a dialogue about partnering to make a better Minnesota for our aging population.

## ■ ■ □ Contact Information on Minnesota's Area Agencies on Aging

Working Together for Older Minnesotans [www.mn4a.org](http://www.mn4a.org)

<b>Agency Information</b>	<b>Counties Served</b>	<b>Contact</b>
Arrowhead Area Agency on Aging Catherine Sampson, Director 221 W. 1 <sup>st</sup> Street Duluth, MN 55802	Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis	Email: <a href="mailto:csampson@ardc.org">csampson@ardc.org</a> Phone: 218-529-7540
Central MN Council on Aging Lori Vrolson, Director 1301 W. St. Germain St. Ste. 101 St. Cloud, MN 56301	Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, Wright	Email: <a href="mailto:lori@cmcoa.org">lori@cmcoa.org</a> Phone: 320-253-9349
Land of the Dancing Sky Area Agency on Aging Darla Waldner, AAA Director 115 S. Main, Suite 1 Warren, MN 56762	Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, Roseau	Email: <a href="mailto:darla@nwrdc.org">darla@nwrdc.org</a> Phone: 218-745-6733
Metropolitan Area Agency on Aging Dawn Simonson, Executive Director 2365 N. McKnight Rd, Suite 3 North St. Paul, MN 55109-2238	Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington	Email: <a href="mailto:dawn@tcaging.org">dawn@tcaging.org</a> Phone: 651-917-4602
Minnesota River Area Agency on Aging <sup>®</sup> , Inc. Linda Giersdorf, Executive Director 10 Civic Center Plaza, Ste. 3 P.O. Box 3323 Mankato, MN 56002-3323	Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Kandiyohi, Lac Qui Parie, Le Sueur, Lincoln, Lyon, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Sibley, Swift, Waseca, Watonwan, Yellow Medicine	Email: <a href="mailto:lindag@rncd.mankato.mn.us">lindag@rncd.mankato.mn.us</a> Phone: 507-389-8866
Southeastern MN Area Agency on Aging Connie Bagley, Executive Director 421 SW 1 <sup>st</sup> Avenue, Suite 201 Rochester, MN 55902	Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona	Email: <a href="mailto:connie@semaaa.rochester.mn.org">connie@semaaa.rochester.mn.org</a> Phone: 507-288-6944

<b>Agency Information</b>	<b>Counties Served</b>	<b>Contact</b>
MN Chippewa Tribe Area Agency on Aging Vera Brown, MIAAA Elderly Program Mgr. P.O. Box 21715542 State 371 NW Cass Lake, MN 56633	Comprised of the Bois Forte, Fond du Lac, Grand Portage, Leech Lake, Mille Lacs, and White Earth Reservations	Email: <a href="mailto:vbrown@mnchippewatribe.org">vbrown@mnchippewatribe.org</a> Phone: 218-335-8585 Toll Free Phone: 1-888-231-7886



## Linkage Line / Resources Directory Information

### Senior LinkAge Line®



A One Stop Shop for Minnesota Seniors

[Senior LinkAge Line®](http://www.minnesotahelp.info), **1-800-333-2433**, is Minnesota’s one stop shop for seniors. The Senior LinkAge Line® is a Program of the MN Board on Aging and operated through the Area Agencies on Aging to connect individuals throughout Minnesota with local services.

Senior LinkAge Line® information specialists connect older adults to the resources. Specialists:

- Evaluate complex living situations to determine the help each individual needs
- Connect older adults and their caregivers to resources for housing, transportation, chore help, legal services, caregiver support and more
- Answer Medicare and insurance questions and help persons of all ages access the prescriptions they need
- Follow up to ensure needs are met

For more information, call to speak to a Senior LinkAge Line® specialist **1-800-333-2433**, visit the Senior LinkAge Line® website at [www.minnesotahelp.info](http://www.minnesotahelp.info), or visit the Minnesota Aging website at [www.mnaging.org](http://www.mnaging.org).

### MinnesotaHelp.info®

## [MinnesotaHelp.info](http://www.minnesotahelp.info)

The [MinnesotaHelp.info®](http://www.minnesotahelp.info) website is a comprehensive database of community resources for individuals, caregivers, and service providers. Search for resources by keywords, topics, or geographic area. Don’t miss the Long-term Care Choices Navigator. It will help you find community services and other resources to address long-term care needs. The step-by-step guide is easy to use and you can save your search results to access later.

### Eldercare Locator

The [Eldercare Locator](http://www.eldercare.gov) is a public service of the U.S. Administration on Aging. It connects you to services for older adults and their families throughout the U.S.. Eldercare locator can also be reached at 1-800-677-1116.

## ■ ■ □ Disability Linkage Line®



Want help on the phone?  
Call the Disability Linkage Line®

To learn about resources for Minnesotans with disabilities or chronic illnesses, visit the [Disability Linkage Line](#) or, to talk one-on-one with a specialist, call **1-866-333-2466**. The Disability Link makes it easy to explore options and make decisions about services, benefits, employment, health care, and more.

<http://mn.db101.org/> Offers quick, easy, safe access to facts, tools and the help you need to understand disability benefits, explore work incentives, and balance work and benefits so you can increase your income.

## ■ ■ □ Pension Counseling Service



Pension counseling helps people understand their pension rights and claim the benefits they've earned, regardless of the type of company they worked for or the type of pension plan involved. Services are provided free of charge. The [Upper Midwest Pension Rights Project \(UMPRP\)](#) is funded by the U.S. Administration on Aging to provide free legal counseling services to individuals in the five state region of Minnesota, Wisconsin, Iowa, North Dakota, and South Dakota.

## ■ ■ □ Veterans Linkage Line™



Visit the [Veterans Linkage Line](#) for information and service for Minnesota veterans. Call **1-888-LinkVet (1-888-546-5838)** for the toll-free LinkVet.

## ■ ■ □ Center for Independent Living

<http://www.macil.org/>

Provides information about independent living services provided by Minnesota's eight Centers for Independent Living (CILs), and links to disability related information around the world.

## ■ ■ □ Hospital and Health Care Home Referrals to the Senior LinkAge Line®

Please visit the following link for a copy of the referral form:

<https://mnhelpreferral.revation.com/>



## Financial Resources for Services



### Medicare

Traditional Medicare includes Medicare Part A and Part B on a fee for service basis; Part C under a managed care (Medicare Advantage) model and Part D for prescription drugs. Summary of Medicare benefits and coverage options can be found at [www.medicare.gov/Publications/Pubs/pdf/10050.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf).

### Home Care

For Medicare home care, there are specific conditions that must be met in order for the patient returning home to receive a Medicare-covered home care benefit:

To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be confined to his/her home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy, or speech-language pathology services. Being "confined to the home" does not mean a beneficiary can never leave the home. (See Chapter 7 of the Benefit Policy publication for the definition of homebound.)

A beneficiary who requires one or more of these services in the treatment of his/her illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his/her behalf for the skilled nursing, physical therapy or speech-language pathology services he needs, as well as for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, a patient who does not require intermittent skilled nursing or physical therapy or speech-language pathology services cannot qualify to have payment made under the program for any home health services furnished him.

Excluded as home health services are the costs of housekeepers, food service arrangements, and transportation to outpatient facilities. To be covered, the home health services must be needed for a condition for which the patient required inpatient hospital services or extended care services. Discharge from the hospital must have occurred in a month in which the patient has attained age 65 or was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law. Home health services are services provided by a home health agency or by others under arrangements with such an agency.

### Skilled Nursing Facility Care

Traditional Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a **3-day minimum medically-necessary inpatient hospital stay** for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare **doesn't** cover long-term care or custodial care.

- You pay nothing for the first 20 days each benefit period.
- You will have a co-pay for days 21–100 each benefit period.
- You pay all costs for each day after day 100 in a benefit period.

Note: These rules apply to traditional Medicare. Please refer the beneficiary to their Medicare Plan for coverage details.

## ■ ■ □ Medicaid (or Medical Assistance in Minnesota)

**Each state operates a Medicaid program that provides health coverage for lower-income people, families and children, the elderly, and people with disabilities.**

The eligibility rules for Medicaid are different for each state, but most states offer coverage for adults with children and adults 65+ at some income level. In addition, beginning in 2014, most adults under age 65 with individual incomes up to about \$15,000 per year will qualify for Medicaid in every state.

In Minnesota all Medicaid recipients are enrolled in a managed care program, and, as a result, will have their own care coordinator/case manager overseeing their care.

## ■ ■ □ Veterans Programs

Access the VA system

<http://www.va.gov/opa/newtova.asp>

State Information

Minnesota Dept. of Veterans Affairs, <http://www.mdva.state.mn.us/>

Minnesota Veterans Homes, <http://www.mdva.state.mn.us/>

The **County Veterans Service Officers (CVSO)** are usually your first contact to assist you with VA benefits and issues. Please view the list of Minnesota counties to contact your local CVSO. <http://www.macvso.org/>

## ■ ■ □ Third Party Payment (Various Insurance Products)

Products vary greatly in Minnesota. Individual policies would need to be reviewed for coverage and payment restrictions.





## Commonly Used Acronyms

Acronym	Term
AAA	Area Agencies on Aging
AC	Alternative Care
ADA	Americans with Disabilities Act
CAC	Community Alternative Care
CADI	Community Alternatives for Disabled Individuals
CMS	Center for Medicaid and Medicare Services
DD	Developmentally Disabled
DHS	Minnesota Department of Human Services
DSD	Disability Services Division
EAP	Energy Assistance Program
EVS	Eligibility Verification System
EW	Elderly Waiver
FC	Foster Care
FS	Food Support, formerly known as Food Stamps
FW	Financial Worker
HHS	Health and Human Services
IEP	Individual Educational Plan
LOC	Level of Care
LTC	Long Term Care
LTCC	Long Term Care Consultation
MAPCP	Multi-Payer Advanced Primary Care Practice
MA	Medical Assistance, also known as Medicaid or Title XIX
MHCP	Minnesota Health Care Programs
MMIS	Medicaid Management Information System
MN	Minnesota
MNIIts	Minnesota Information Technology System
PCA	Personal Care Attendant
PMAP	Prepaid Medical Assistance Program
PMI	Person Master Index
QMB	Qualified Medicare Beneficiary
QWD	Qualified Working Disabled
SLMB	Specified Low-Income Medicare Beneficiary

Acronym	Term
SMRT	State Medical Review Team
SNAP	Supplemental Nutrition Assistance Program, Food Support
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SSN	Social Security Number
TANF	Temporary Assistance for Needy Families
VA	Veteran's Administration
WIC	Women, Infants, and Children



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