Health Care Home Care Coordination

Toolkit for Working with Persons with Complex Needs and Older Adults

AUGUST 2013 VERSION

This toolkit was created as a part of the Medicare Multipayer Advanced Primary Care Provider (MAPCP) Demonstration Project.
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 seniors and people with disabilities 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 is conducting 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 is available at

http://www.health.state.mn.us/healthreform/homes/medicare/index.html

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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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 “Care Partner” (might accompany the patient to primary care visits, provide medication set up, etc.)
- Identify caregiver supports (If a caregiver is involved conduct the Caregiver Assessment found on page 7 of the Toolkit.)
- 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
- 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)
Caregivers are those individuals who provide support, assistance, or oversight to help a person sustain their health and living arrangements. They are a very important member of the care team and need to be involved in the discussions and care planning. Their role in the patient’s life needs to be acknowledged and supported in order to continue their ability to care for their loved one. What follows is a link to caregiver resources and tools and a copy of a “Caregiver Assessment” tool.

**MBA Caregiver Page**: general information about family caregivers of older adults

**Healthy Aging Minnesota**: information about Powerful Tools for Caregivers and Family Memory Care

**Live Well at Home**: information about Live Well at Home, a resource tool for older adults and the people who help them
A caregiver is defined as anyone providing support, assistance, or oversight (supervision) to help a person sustain their health and/or living arrangement.

As a caregiver, you play a vital role in this person’s life. Your continued health and the strength of your own support network are key to maintaining your ability to care for this person. Please complete the following form. The social worker or public health nurse will want to review this with you at an initial consultation or reassessment visit. Thank you.

<table>
<thead>
<tr>
<th>NAME:</th>
<th></th>
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<tbody>
<tr>
<td>CAREGIVER NAME:</td>
<td></td>
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<tr>
<td>DATE SENT:</td>
<td></td>
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</table>

1. What kind of help do you give this person?

<table>
<thead>
<tr>
<th>Types of Help Given (Check all that apply)</th>
<th>How often?</th>
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<tbody>
<tr>
<td>Medication Administration</td>
<td>□</td>
</tr>
<tr>
<td>Personal Care</td>
<td>□</td>
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<tr>
<td>Housekeeping</td>
<td>□</td>
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<tr>
<td>Meal Preparation</td>
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<tr>
<td>Transportation</td>
<td>□</td>
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<tr>
<td>Laundry</td>
<td>□</td>
</tr>
<tr>
<td>Shopping and Errands</td>
<td>□</td>
</tr>
<tr>
<td>Supervision for Safety</td>
<td>□</td>
</tr>
<tr>
<td>Money Management</td>
<td>□</td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td>□</td>
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</tbody>
</table>

2. Are you employed?  □Full time  □Part Time  □Not employed

3. If you were unable to continue providing care, who would take your place? □Nobody  Other:  

4. How is your own health?  □Excellent  □Good  □Fair  □Poor
5. How has caring for this person affected other area of your life; such as work, health, and relationships with family and friends?

6. What makes it difficult for you to continue caring for this person?

7. How long have you been a “caregiver” for this person?

8. How would you rate your level of burden in caring for this person?
   ☐ None  ☐ Low  ☐ Medium  ☐ High

9. What caregiver service are you presently receiving (if any)? Examples: respite, caregiver coaching, education and training, care coordination, support group, etc.

10. Are you interested in more information about caregiving?
    ☐ Yes  ☐ No

    ☐ Support Groups

    ☐ Education / Training Opportunities
    • Seminars
    • Websites
    • Reading Materials
    • Monthly Publications

    ☐ Specific Information about a Disease

    ☐ Caregiver Coaching

    ☐ Respite Opportunities

11. What specific information would be useful to you?

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Thank you for completing this caregiver survey. Please let us know if there are any other areas of concern.

This tool was adapted by Dakota County and taken from the Long Term Care Consultation Assessment Tool developed by the Department of Human Services for Long Term Care Consultants to use in their assessment of older adults and caregivers.
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.
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.

<table>
<thead>
<tr>
<th>Title</th>
<th>Possible Program/Health Provider Funding this Role</th>
<th>Roles and Responsibilities of this Title</th>
<th>System used to Locate the Care Coordinator Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordinator, Care Manager, Case Manager, Service Coordinator</td>
<td>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)</td>
<td>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.</td>
<td>MNIts (Minnesota Information Technology System), Health Plan, Care System</td>
</tr>
<tr>
<td>*these services require the patient to be on Medical Assistance</td>
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</table>
| Care Manager (also known as Geriatric Care Manager) | Private Pay Examples of agencies that provide this service: DARTS, Volunteers of America, Pathfinders, Jewish Family Services, | Professional staff (RN or SW) who provide:  
• Comprehensive assessment of an older adult’s situation  
• A plan of care developed in collaboration with the older adult, family members and health care providers  
• Monitoring of the plan on an ongoing basis with phone calls and visits to ensure that needs are being met  
• Communication with out-of-town family members to keep them apprised  
• Advocate with healthcare providers on behalf of the older adult, including accompanying the older adult to | Contact the agency that is providing this service |

*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.
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<tr>
<td>Care Navigator</td>
<td>Private Health Insurers or Health Systems. May be tied to a specific disease process eg. Breast cancer, Chronic Pain</td>
<td>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.</td>
<td>Client’s insurance or Health Plan</td>
</tr>
<tr>
<td>Targeted Case Manager</td>
<td>Medical Assistance</td>
<td>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.</td>
<td>MNIts, MMIS</td>
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</table>
| Caregiver Consultant          | Title III Funding which comes from the Federal Older Americans Act. | An individual support service provided by a trained professional that equips caregivers with the knowledge, skills and tools to develop themselves and perform their caregiver role.  

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                                                                                                                                                                                                 | Area Agencies on Aging                               |
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Heath Care Home(HCH) Care Coordinator, Community Coordinator, Transition Planner</td>
<td>Certified Health Care Homes</td>
<td>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.</td>
<td>The clinic where the consumer receives their primary care.</td>
</tr>
<tr>
<td>Community Living Specialist</td>
<td>Area Agencies on Aging through the Minnesota Board on Aging</td>
<td>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.</td>
<td>Senior LinkAge Line®</td>
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</table>
| Live Well at Home Provider | Area Agencies on Aging and other providers working with the Live Well At Home Project | The Live Well at Home Provider uses the LWAH Rapid Screen to:  
  - Identify an older adult’s personal risks that could cause them to move from their home.  
  - Assess older adult’s needs and community living goals.  
  - Provide education, counseling and coordination support | Area Agencies on Aging |
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<tr>
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</table>
| Support Planner (Previously known as a Flexible Case Manager) | Alternative Care Brain Injury Community Alternatives for Disabled Individuals, Elderly Waiver Minnesota Senior Health Options | 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:  
• Helping people to select, employ, train, and schedule their own direct care workers  
• Defining worker responsibilities and tasks  
• Evaluating and monitoring results  
• Creating and modifying the person’s individual plan and budget  
• Advocating and problem solving  
• Coordinating service delivery  
• Arranging for other services as needed for the person to remain at home | 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. |
<p>| Alzheimer’s Association Care Consultant | Alzheimer’s Association | 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: | Call the Alzheimer’s Association 24/7 Information Helpline at 1.800.272.3900 and request a care |</p>
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<tr>
<td></td>
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<td>Identifying your current needs</td>
<td>consultation today</td>
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<td>Assistance with developing a plan</td>
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<td></td>
<td></td>
<td>Assistance with finding resources and services</td>
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<tr>
<td></td>
<td></td>
<td>Problem-solving</td>
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<td></td>
<td></td>
<td>Providing education and support</td>
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<td></td>
<td></td>
<td>Providing ongoing support and follow-up</td>
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</table>
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]:

<table>
<thead>
<tr>
<th>The Care Transitions Program®</th>
<th>The Transitional Care Model</th>
<th>Better Outcomes for Older Adults through Safe Transitions (BOOST)</th>
<th>The Bridge Model</th>
<th>Guided Care®</th>
<th>Geriatric Resources for Assessment of and Care of Elders (GRACE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Coach helps patients and families learn transition-specific self-management by:</td>
<td>The Transitional Care nurse:</td>
<td>BOOST includes specific interventions to mitigate high risk patients’ risks for adverse events:</td>
<td>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:</td>
<td>Program requires that Guided Care Nurse:</td>
<td>Program requires that nurse practitioner and social worker:</td>
</tr>
<tr>
<td>• Conducting a hospital visit to introduce the program and tools such as the Personal Health Record (PHR)</td>
<td>• Visits patient in the hospital to:</td>
<td>• A standardized discharge process</td>
<td>• Conduct a comprehensive home assessment</td>
<td>• Offer in-home assessment and care management</td>
<td>• Collaborate with and support the primary care physician</td>
</tr>
<tr>
<td>• Conducting one home visit 24-72 hours post-discharge:</td>
<td>1. Conduct an in-hospital assessment (+ functional status)</td>
<td>• Efforts to improve patient/caregiver preparedness</td>
<td>• Create a care guide and an action plan for the patient</td>
<td>• Meet with the patient’s primary care physician to review, modify</td>
<td>• Follow-up care</td>
</tr>
<tr>
<td>1. Actively engages patients in</td>
<td>2. Collaborate with care-team members to reduce adverse events and</td>
<td>• Medication safety</td>
<td>• Intensive care coordination that starts in the hospital and continues after discharge to the community</td>
<td>• Provide monthly monitoring and self-management coaching</td>
<td>• Tool for Addressing Risk: a Geriatric Evaluation for Transitions (TARGET)</td>
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<tr>
<td></td>
<td></td>
<td>• Follow-up care</td>
<td></td>
<td></td>
<td>• Aging Resource Centers (ARC) inside hospitals that</td>
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<tr>
<td></td>
<td></td>
<td>• Tool for Addressing Risk: a Geriatric Evaluation for Transitions (TARGET)</td>
<td></td>
<td></td>
<td>• Smooth transitions into and out of</td>
</tr>
<tr>
<td>The Care Transitions Program ®</td>
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<tr>
<td>medication management; helps them develop a clear, easily understandable medication regimen and enter into PHR</td>
<td>• prevent functional decline</td>
<td>is a 4-part tool that includes:</td>
<td>• 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.</td>
<td>• hospitals and other institutions</td>
<td>• and prioritize the care plan, then collaborate with the physician</td>
</tr>
<tr>
<td>2. Uses role-playing and other tools to teach skills to patients and family members on how to communicate needs with health care professionals</td>
<td>• Develop a streamlined, evidence-based plan of care</td>
<td>• Risk stratification process using eight elements</td>
<td>• Coordinate care by all providers</td>
<td>• Work weekly with geriatrician-led interdisciplinary team to craft patient care plan</td>
<td></td>
</tr>
<tr>
<td>3. Reviews any “red flags” that indicate a worsening condition, and response strategies</td>
<td>• 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</td>
<td>• Risk-specific intervention plan linked to the 8P risk score summary</td>
<td>• Provide family caregiver education/support</td>
<td>• Conduct at least one in-home follow-up visit to review care plan, and one telephone or face-to-face contact per month</td>
<td></td>
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<tr>
<td>• Making three follow</td>
<td>• Accompanies patient on first visit with the</td>
<td>• Universal set of expectations for all patients being discharged from the hospital to home (the Universal Checklist)</td>
<td>• Facilitate access to community based services</td>
<td>• Coordinate care from all providers</td>
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<tr>
<td></td>
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<td>4. General Assessment of Preparedness (GAP), a component list of issues important to providers and patients (and their caregivers)</td>
<td>• 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 services prior to discharge. BCCs also prepare for discharge by</td>
<td>• Collaborate with hospital discharge planners and make a home visit after any hospitalization</td>
<td></td>
</tr>
<tr>
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<td>The Transitional Care Model</td>
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<tr>
<td>up phone calls focused on reviewing the progress toward established goals, reinforcing the importance of maintaining PHR, and supporting the patient’s self-management</td>
<td>physician post-discharge and subsequent visits if needed</td>
<td>reviewing medical records or meeting with an interdisciplinary team within the hospital.</td>
<td>Facilitates physician-nurse collaboration across care episodes</td>
<td>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 care, difficulty obtaining and/or understanding medications.</td>
<td>Geriatric Resources for Assessment of and Care of Elders (GRACE)</td>
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<td></td>
<td>• Facilitates physician-nurse collaboration across care episodes</td>
<td>• 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 care, difficulty obtaining and/or understanding medications.</td>
<td>• Conducts weekly home visits for first month</td>
<td>• Follow-up: The BCC</td>
<td></td>
</tr>
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<td></td>
<td>• Makes telephone contact for each week that in-person visit is not scheduled</td>
<td>• 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 care, difficulty obtaining and/or understanding medications.</td>
<td>• Is on call seven days per week for home visits and telephone access</td>
<td>• Follow-up: The BCC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provides active engagement of patients and family caregivers with focus on</td>
<td>• 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 care, difficulty obtaining and/or understanding medications.</td>
<td>• Provides active engagement of patients and family caregivers with focus on</td>
<td>• Follow-up: The BCC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>surrounding the readiness of patients for transition out of hospital</td>
<td>• 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 care, difficulty obtaining and/or understanding medications.</td>
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<td>The Care Transitions Program</td>
<td>The Transitional Care Model</td>
<td>Better Outcomes for Older Adults through Safe Transitions (BOOST)</td>
<td>The Bridge Model</td>
<td>Guided Care®</td>
<td>Geriatric Resources for Assessment of and Care of Elders (GRACE)</td>
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<td>follows up with consumers at 30 days post-discharge to track their progress and address needs</td>
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<td>• Provides communication to, between, and among the patient, family caregivers, and health care providers</td>
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Health Care Home | Care Coordination | August 2013
Medication Management

Best Practices/Strategies for Improvement of Medication Management

Taken from Reducing Avoidable Readmissions Effective (RARE) Campaign (http://www.rarereadmissions.org/areas/medmanagement.html)

Best Practices

• Assess patient’s knowledge of medications on admission, using Teach Back and communicate this information with other 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 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

Tools/Resources

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).

Improving Medication Reconciliation during Transitions. 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.1

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.2

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

Link to Beers Criteria: [http://www.dcri.org/trial-participation/the-beers-list/](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.


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.
**Act on Alzheimer’s Description and Practice Tools**

**Designed by Leading Health Care Practitioners and Community Providers**

ACT on Alzheimer’s is a statewide collaboration seeking to address the personal, social and budgetary impacts of Alzheimer’s disease and related dementias. We have come together – health care providers, community members, government officials, caregivers, people with Alzheimer’s, academics, and businesses – to better support individuals with Alzheimer’s disease and their families. The link below will connect you to the ACT on Alzheimer’s website where you will find useful information and tools: [http://www.actonalz.org/improve-care](http://www.actonalz.org/improve-care)

**Provider Practice Tools**

The Clinical Provider Practice Tool and Care Coordination Practice Tools can be accessed at: [http://www.actonalz.org/provider-practice-tools](http://www.actonalz.org/provider-practice-tools)

Clinical Provider Practice Tool: Disease screening, detection and treatment is critical to reducing the severity of Alzheimer’s and related dementias and improves the quality of life and care for persons with the disease and their care partners. ACT on Alzheimer’s has developed a recommended practice tool using best evidence and the expertise of a multi-stakeholder community of clinical and community-based service providers. Note the importance of community based services in the recommended care practices and establish relationships with community based service organizations that are using a similar approach to care.

Care Coordination Practice Tool: Care coordination in health care settings is one of the most important aspects of providing quality care to patients with dementia. ACT on Alzheimer’s has developed a practice tool to support patients with dementia and their care partners using best evidence and the expertise of a multi-stakeholder community of clinical and community-based service providers.
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

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-_k-E5g

Family Questionnaire

Family Questionnaire and Scoring

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.

When considering whether services should be brought into your home or whether a housing move is necessary ask yourself the following questions:

- 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/](http://www.homemods.org/)
2. Senior Home Safety Assessment: [http://www.eldercareteam.com/public/390.cfm](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 who provide 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 the site below. [http://minnesotahelp.info/public](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](http://www.mnfallsprevention.org)
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.agencymeddirectories.wa.gov/Files/depressoverview.pdf

Cornell University Depression Scale

Geriatric Depression Scale
This scale was developed as a basic screening measure for depression in older adults.
http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF
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 Institute of Mental Health


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
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.

The link to the Minnesota Network of Hospice and Palliative Care below provides additional links to several health care directive forms, Honoring Choices and Minnesota Health Care Directive, which are also available in a variety of languages. It contains good information about Hospice and Palliative Care services.

http://mnhpc.org/public/programs/advance-care-planning/acp-resource

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://mnhpc.org/public/programs-services/polst
The Multi-Payer Advanced Primary Care Practice Demonstration is 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- chronic disease has tremendous impact on both an individual’s quality of life and cost. A successful approach to self-management and avoiding hospitalization requires a community wide response and the AAAs are pivotal to successful response.
- 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. Our 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 how we can partner 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)

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<th>Agency Information</th>
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<tr>
<td>Arrowhead Area Agency on Aging</td>
<td>Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis</td>
<td>Email: <a href="mailto:csampson@ardc.org">csampson@ardc.org</a> Phone: 218-529-7540</td>
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<tr>
<td>Catherine Sampson, Director</td>
<td>221 W. 1st Street</td>
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<td>Duluth, MN 55802</td>
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<td>Central MN Council on Aging</td>
<td>Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, Wright</td>
<td>Email: <a href="mailto:lori@cmcoa.org">lori@cmcoa.org</a> Phone: 320-253-9349</td>
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<tr>
<td>Lori Vrolson, Director</td>
<td>1301 W. St. Germain St. Ste. 101 St. Cloud, MN 56301</td>
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<tr>
<td>Land of the Dancing Sky Area Agency on Aging</td>
<td>Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, Roseau</td>
<td>Email: <a href="mailto:darla@nwrdc.org">darla@nwrdc.org</a> Phone: 218-745-6733</td>
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<tr>
<td>Darla Waldner, AAA Director</td>
<td>115 S. Main, Suite 1</td>
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<tr>
<td>Warren, MN 56762</td>
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<tr>
<td>Metropolitan Area Agency on Aging</td>
<td>Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington</td>
<td>Email: <a href="mailto:dawn@tcaging.org">dawn@tcaging.org</a> Phone: 651-917-4602</td>
</tr>
<tr>
<td>Dawn Simonson, Executive Director</td>
<td>2365 N. McKnight Rd, Suite 3</td>
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<tr>
<td>North St. Paul, MN 55109-2238</td>
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<tr>
<td>Minnesota River Area Agency on Aging, Inc.</td>
<td>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</td>
<td>Email: <a href="mailto:lindag@rndc.mankato.mn.us">lindag@rndc.mankato.mn.us</a> Phone: 507-389-8866</td>
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<tr>
<td>Linda Giersdorf, Executive Director</td>
<td>10 Civic Center Plaza, Ste. 3</td>
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<tr>
<td>P.O. Box 3323</td>
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<td>Mankato, MN 56002-3323</td>
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<td>Southeastern MN Area Agency on Aging</td>
<td>Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona</td>
<td>Email: <a href="mailto:connie@semaaa.rochester.mn.org">connie@semaaa.rochester.mn.org</a> Phone: 507-288-6944</td>
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<tr>
<td>Connie Bagley, Executive Director</td>
<td>421 SW 1st Avenue, Suite 201</td>
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<tr>
<td>Rochester, MN 55902</td>
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<td><strong>Agency Information</strong></td>
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<tr>
<td>MN Chippewa Tribe Area Agency on Aging</td>
<td>Comprised of the Bois Forte, Fond du Lac, Grand Portage, Leech Lake, Mille Lacs, and White Earth Reservations</td>
<td>Email: <a href="mailto:vbrown@mnchippewatribe.org">vbrown@mnchippewatribe.org</a> Phone: 218-335-8585 Toll Free Phone: 1-888-231-7886</td>
</tr>
<tr>
<td>Vera Brown, MIAAA Elderly Program Mgr. P.O.</td>
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<tr>
<td>Box 21715542 State 371 NW</td>
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<td>Cass Lake, MN 56633</td>
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Senior LinkAge Line® 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, or visit the Minnesota Aging website at www.mnaging.org.

MinnesotaHelp.info®

The 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 is a public service of the U.S. Administration on Aging. It connects you to services for older adults and their families. Eldercare locator can also be reached at 1-800-677-1116.
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. DB101.org

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 can help you understand your pension rights and claim the benefits you’ve earned, regardless of the type of company you 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.

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.

Protocols for Hospital and Health Care Home Referrals to the Senior LinkAge Line®

Please visit the following link for referral protocols:


You can also visit www.mnaging.org for more information.
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**

Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other services and supplies that are [medically necessary](http://www.medicare.gov/) after a [3-day minimum medically-necessary inpatient hospital stay](http://www.medicare.gov/) 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](http://www.medicare.gov/) long-term care or custodial care.

- You pay nothing for the first 20 days each benefit period.
- You pay $144.50 per day for days 21–100 each benefit period.
You pay all costs for each day after day 100 in a benefit period

**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 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/](http://www.mdva.state.mn.us/)

Minnesota Veterans Homes, [http://www.mdva.state.mn.us/](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/](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.
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<thead>
<tr>
<th>Acronym</th>
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<td>Area Agencies on Aging</td>
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<td>Alternative Care</td>
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<td>Americans with Disabilities Act</td>
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<td>Individual Educational Plan</td>
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<td>Level of Care</td>
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Acknowledgements

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