Ambulatory Geriatric Clinical Care and Services

American Geriatrics Society (AGS) Position Statement

With the growth of the older adult population, community-based elder health services are becoming attractive entrepreneurial opportunities and critical components of the continuum of care for many health systems. Specialized ambulatory clinical service centers for older adults (hereafter referred to as "senior clinics") are being developed and marketed to the public. They vary widely in mission, scope of available services, background and skills of providers, and overall capacity.

The American Geriatrics Society (AGS) believes that high-quality ambulatory care services for older adults must contain 7 critical components: primary as well as consultative care; personnel with training and experience in geriatrics; an interdisciplinary team able to coordinate care and services; access to care that is considerate of the special needs of many elders; an information system and quality improvement program that is geriatric-focused; and financial viability to ensure continuity of care. While most senior clinics are affiliated with hospitals or part of a large group practice, some of the points made in this statement may also apply to a private office with general internists or family practitioners who see many geriatric patients. However, the intent of this position paper is to describe the necessary components of specialized ambulatory care clinics dedicated to older patients. This position paper does not apply to dedicated geriatric consultation services, such as geriatric assessment clinics, which typically do not provide primary care or ongoing coordination of health services for older adults.

Positions

1. A primary care geriatric medical delivery model should be seen as the gold standard in delivering high-quality care to the senior population.

Rationale: Patients should be given the opportunity to utilize the senior clinic for primary care services. Continuity with a group of experienced providers, who are available to manage care across the continuum, is essential for older persons. The patient should be provided information and materials to enable him or her to participate in self-management of chronic disease, whenever possible. Senior clinics may also offer consultation, such as Comprehensive Geriatric Assessment and specialty consultations, to other primary care physicians but must ensure adequate follow-up of patients. Opportunities for the consulting team to play a role in implementing suggestions should be encouraged because evidence suggests that clinical outcomes are improved when there is integration between the recommendations that are generated by geriatric assessment and the implementation of those care processes.

2. All providers must have an appropriate level of competency in geriatrics.

Rationale: Senior clinics often manage complicated elders with multiple medical comorbidities, functional deficits, complex medical regimens, and a high rate of mental health problems. Physicians should have fellowship training in geriatrics, a Certificate of Added Qualifications in geriatrics, or extensive experience and continuing education in geriatrics. Geriatric nurse practitioners, registered nurses, and other health professionals should

have either advanced training or sufficient continuing education in geriatrics. Staff throughout the program must receive sensitivity training for the elderly population.

3. An interdisciplinary team approach to care must be available.

Rationale: In addition to traditional medical care, comprehensive geriatric care involves attention to the patient's psychological, social, and functional needs. The team is responsible for developing and carrying out a plan of care. Regular meetings and documentation of team interactions should occur. A close working relationship with a social worker skilled in geriatric care is imperative. A senior clinic must provide a mechanism for the interdisciplinary team to function effectively, including necessary information systems, scheduled time for meetings, and documentation of decision making.

Primary geriatric care encompasses the entire continuum of care, including hospital, skilled nursing facility, assisted living, and home care. A care coordinator or case manager (usually a nurse or a social worker) should be available to facilitate the care. The team members involved in the senior clinic must be able to work with patients, families, and caregivers. There must be adequate interchange with community-based services to ensure safety and assistance when needed.

4. Access that is sensitive to the needs of geriatric patients must be ensured.

Rationale: Many elders have limitations in sensory functions or mobility and special transportation needs. A senior clinic must be accessible by public transportation and have readily available parking or parking services. Privacy and confidentiality must be ensured, especially when discussing billing and insurance issues. The clinic must be physically accessible with parking for disabled individuals, adequate lighting, wheel chair and walker accessibility, rest rooms, and appropriate examination tables. There should be telephone access for the hearing impaired. A resource library with community resource information should be available. All attempts must be made to fulfill the transportation needs of the patients served by the program.

5. The program must have an appropriate information system to allow for tracking of key clinical items (eg, preventive services, diagnoses, medications, and advance directive status).

Rationale: An adequate information system is needed to manage the vast amount of clinical data on complex geriatric patients. Ideally, programs should be able to transfer information to different care sites, including hospitals, nursing homes, other community-based care facilities, and social services agencies. Data should be maintained on important clinical activities and outcomes to allow patients and others to judge quality of care.

6. Quality improvement programs must demonstrate, at a minimum, compliance with key geriatric indicators.

Rationale: The program must have a defined set of health promotion and disease prevention activities based on sound geriatric principles and patient preference and individuality. Specialized programs for the detection, evaluation, and management of incontinence, falls, degenerative joint disease, depression, and dementia are advised. A mechanism for screening and treating functional disabilities should be established. New patients should be screened for high risk for hospitalization and functional disability. Ongoing clinical quality monitoring should include attention to immunizations, prevention of advancement of chronic disease or disability, pain control, end-of-life care, and satisfaction with care.

7. A program focusing on the senior population will by its very nature require more financial resources than the traditional approach to care.

Rationale: In the fee-for-service environment, interventions common in geriatrics such as case management may not be reimbursable. Senior clinics adopt innovative financial approaches to expand services into those areas most needed but often not covered by traditional Medicare or supplemental insurance. Medicare should expand the billable activities that are critical to management of complex older patient's care, such as case management, palliative care, and family conferences.

In the managed care environment, senior citizens often need more time to interact with their providers. Traditional productivity measurements for providers must be reevaluated. It is critical that overall healthcare costs be taken into account in assessing the financial viability of such a program. Certain target areas such as reduced use of hospital resources, the appropriate use of skilled nursing care as an alternative to hospitalization, enhanced home care, improved pharmaceutical management, and more appropriate specialty utilization need to be considered in the financial model. Alternative methods for risk adjustment or capitated payments for frail elders with complex needs offer special opportunities in the managed care environment. Programs must provide information to clients and their families regarding current coverage and benefits and limits of reimbursement. ALC

Developed by the AGS Health Care Systems Committee and approved May 2000 by the AGS Board of Directors. The AGS thanks Michael Wasserman, MD, Kenneth Brummel-Smith, MD, Cheryl Phillips, MD, and Steven Phillips, MD for their work on this statement.