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LONG-TERM CARE

The Need for Geriatric Assessment in Publicly Funded Home and Community-Based Programs

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Madam Chairman and Members of the Committee:

It is a pleasure to be here to share with you the results of our ongoing work on how elderly clients are assessed for publicly funded home and community-based long-term care. As you requested, in our testimony today, we will present information on geriatric assessment--also called "geriatric evaluation," or simply "assessment"--including (1) what it is and how it is used, (2) the extent to which it is available in public programs, (3) the professional requirements for the persons who administer it, and (4) some of the pros and cons with regard to standardization of the evaluation process. In this testimony, we use the words "evaluation" and "assessment" synonymously. Before reporting our findings, let me turn to some background information to establish the context in which geriatric assessment has become important.

BACKGROUND

Some Demographics and Their Implications

Because of advances in medicine and public health, as well as other factors, Americans are living longer than ever before. The Bureau of the Census reports that 31 million elderly persons

--nearly 1 of every 8 Americans--were 65 years of age or older in 1990. The elderly population is expected to reach 52 million by 2020, representing about 1 of every 5 Americans.

Within the 65 and older age group, however, not all segments of the population are changing in the same way: the proportion of persons age 65-74 is getting smaller, while the proportion of people age 75 and older is getting larger. Indeed, the segment of our population that is expected to grow most rapidly consists of persons 75 years of age and older.

This increasing size and proportion of our elderly population and its increasing age have implications with respect to the need for support services, since the prevalence of most chronic diseases, and therefore disability, increases with age. Chronic diseases, including cognitive diseases and impairing illnesses, are associated with an increase in limitations on activities of daily living (ADLs)--for example, bathing and dressing--or limitations on instrumental activities of daily living (IADLs)--for example, shopping and preparing meals. Individuals who experience ADL or IADL limitations may require supportive environments in order to maintain semi-independence in the community. According to the 1987 National Medical Expenditure Survey, about 11 percent of persons age 65 to 74 living in the community have some limitation for which they

require assistance; this figure climbs to 57 percent among persons age 85 and older.

For every person age 65 and older residing in a nursing home, there are nearly two living in the community who require some form of long-term support. According to a Brookings Institution report, approximately 4.9 million elderly persons who had ADL limitations were residing in the community in 1985 (18 percent of the population over age 65). About two thirds of these elderly persons had only moderate impairments--that is, fewer than three ADL limitations. However, some 850,000 elderly persons were severely impaired (which is defined as having a limitation in five or six ADLs).[1]

Federal and State Program Involvement

Home and community-based long-term care services for elderly persons are financed and administered through a complex of federal and state programs, including Medicare, several specific Medicaid services, Social Services Block Grants, programs under the Older Americans Act, and programs funded solely by state revenues. Accordingly, in most states, there is no single point of access to the service system, and the assessments conducted for eligibility and care planning can vary considerably,

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[1]A. M. Rivlin and J. M. Wiener, Caring for the Disabled Elderly: Who Will Pay? (Washington, D.C.: The Brookings Institution, 1988), p. 6.

depending on the particular source of service financing and the type of service provided. This fragmented system may result in elderly persons being evaluated every time they apply for a new program or pass some particular milestone (for example, discharge from a hospital), possibly by different assessment processes, including different data collection instruments or different guidelines for making decisions about care needs on the basis of the same instrument. To the extent that these evaluations are not coordinated or communicated among agencies and other service providers, and alternative assessment methodologies operate, both redundancy among multiple evaluations for the elderly person and conflict in care plans (generated for different programs) may result.

In spite of fragmentation, geriatric assessment is a potentially useful component of any program having frail elderly clients seeking home and community-based long-term care. Such assessment is often perceived, however, as especially relevant to programs that pay for a wide variety of services, as opposed to those providing only one or two services. Multiservice programs include the Medicaid waiver programs found in 42 states.[2] In such programs, each available service may or may not be authorized, depending on a care plan based on geriatric

[2]A Medicaid waiver program covers persons, not all of whom are elderly, needing home and community-based services, if these persons would otherwise require institutional care that would be covered by Medicaid.

evaluation. The proposed Health Security Act (H.R. 3600) describes "state programs for home and community-based services for individuals with disabilities," many of whom are elderly. For these multiple-service programs too, the client's care plan would be dependent upon a needs assessment.[3]

Now let me turn to our findings on geriatric assessment: first, what it is and how it is used.

FINDINGS

Geriatric Assessment: Description and Use in Care Planning

Geriatric assessment or evaluation is the skillful gathering of information about an elderly person's health, needs, and resources. In our review of the literature and interviews with experts in medicine, nursing, and social work, we found considerable agreement about the importance of having a standardized evaluation process available for planning an elderly client's care under publicly funded home and community-based long-term care programs. Geriatric evaluation in this context is not the same as the kind of intensive geriatric evaluation conducted in hospitals, where the predominant emphasis is on physical examination and medical tests. Instead, the emphasis is on functional status, resources, and needs.

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[3]Health Security Act, title II, subtitle B, part 1.

Information that is commonly gathered through geriatric assessment includes data on several dimensions. One of these is physical health. This is usually assessed by asking both general ("How would you rate your health?") and specific ("Have you ever been told by a doctor or nurse that you have arthritis?") questions, including ones about medications being taken. Some assessments also require basic physiological measurements, such as blood pressure. A second dimension is mental health, which typically involves the use of scales designed to measure cognitive status (to check for signs of dementia) and affective status (to check for signs of depression and other mood disorders). General questions about life satisfaction are also often asked.

A third dimension assessed is functional status. This includes inquiries, and possibly observations, about the client's performance of ADLs and IADLs. Although sometimes considered an aspect of physical health instead of a separate dimension, the measuring of the client's functioning is so critical that the entire multidimensional assessment is sometimes referred to as a "functional assessment." Moreover, as noted, the eligibility criteria for specific programs are often stated in terms of the number of ADL limitations.

A fourth dimension that is always relevant concerns social supports. Here the client is asked about family and friends,

with emphasis on practical dimensions such as how close they live and how willing they are to help under particular circumstances. A fifth dimension is economic resources. Depending on whether a program is means tested, it may or may not make sense to ask about the client's economic resources (income, reserves, insurance, and so forth). A sixth dimension, the home environment, including the neighborhood, is often assessed, with emphasis on both objective health and safety hazards and subjective feelings of comfort or threat. The client is usually also asked about services currently received, if any, and those desired or applied for.

We found that, although there is considerable agreement among experts that these dimensions should be evaluated, there is some disagreement about how intensively they should be investigated. For example, some experts feel that it is necessary to gather only the client's own self-report about physical health, while others believe that some basic physiological measures should also be taken. Except when impractical in terms of expense, the client's home is considered the best place to conduct such an assessment.

Geriatric assessment typically involves the administration of a set of questions to the client, or to the caregiver if the client is not competent to provide the information, on each dimension of information covered. These questions make up an

assessment instrument that is standardized in the sense that all clients are asked the same questions, unless exempted by some specific rule of the assessment process. It is important to note that clinical skills play a major role in geriatric evaluation. These may include the skills needed to administer a sequence of questions that may be highly complex in its organization, pose follow-up questions, record and interpret ambiguous replies, and arrive at a comprehensive picture of the elderly person's resources and needs. As a result, a given geriatric assessment process is usually fixed in terms of the instrument itself but flexible in terms of how that instrument is used.

Geriatric assessment is used (1) to determine a client's eligibility for a public program, (2) to provide the basis for the client's care plan, and (3) to determine the aggregate needs of a community for services. Geriatric assessment is important in care planning from at least two perspectives. First, sound public policy requires that scarce resources be optimally allocated. For individual clients for home and community-based long-term care, this means that (1) only clients who need a particular service in order to maintain an adequate quality of life in the community should be authorized to receive it and (2) no client should be authorized to receive services not appropriate to his or her needs. This is accomplished by evaluating the needs of the client and then delivering only the needed services. For example, it is critical in care planning to

decide which program services in which amounts (for instance, in hours per week) are appropriate.

Second, major public long-term care programs serve many vulnerable poor elderly persons who may not have enjoyed continuing high-quality medical care through their early years. Assessment is especially important for these clients, who are likely to have multiple health and social problems, some of which may not have been previously identified. In this context, evaluation is essential to obtaining a precise understanding of a client's current situation and its potential effect on both the authorized services and future interactions with the care delivery system.

Using geriatric evaluation in this way alerts staff to many of a client's needs, perhaps including ones that cannot be directly met by a program. Nevertheless, it may be possible to deal with such needs in ways that augment the benefits from program services and forestall future difficulties, such as unnecessary institutionalization. Thus, assessment plays a critical role in care planning because it gives the evaluator the opportunity to (1) <u>inform</u> the client about these needs and potential problems, (2) <u>refer</u> the client to appropriate services where possible, and (3) <u>assist</u> the client in obtaining further help to deal with existing problems and to prevent the development of potential ones. For example, depression may lead

a client to neglect household chores. Based on this need for help with IADLs, chore services may be authorized. However, if the evaluation includes a scale for depression, and the evaluation thereby detects the depression, it may be possible to refer the client to mental health services. If treated successfully, the client may no longer need the chore services originally authorized on the basis of the initial assessment of IADLS. The result in this case would be a happier and healthier client with no need for long-term personal assistance, although possibly with a continuing need for medication.

The appropriateness of a care plan, for both program and nonprogram services, depends on the accuracy of the assessment. The central notion is that the evaluator can either best decide what services a client needs or best convey the needed information to those who will decide. The resulting list of services and, where appropriate, their amounts (for example, hours per week) constitutes a plan of care. The logic of this use of assessment is often also extended to reassessments or periodic monitoring of a client; such reassessments provide the basis for care plan revision when they determine that the client's situation has changed significantly.

The use of geriatric evaluation for community care does not mean that every applicant needs a comprehensive evaluation. As experts have pointed out, a brief screening instrument can be

employed to decide if an applicant's level and type of frailty are such as to require a more comprehensive assessment and perhaps to determine program eligibility as well. It may be, for example, that a client whose functional status is good would benefit relatively little from comprehensive evaluation, since his or her need might be only for a single service to meet a specific need, such as congregate meals in the case of social isolation. At another extreme, a severely cognitively impaired client with a highly burdened informal caregiver might benefit relatively little from comprehensive evaluation, needing institutionalization instead.

The Extent to Which Geriatric Evaluation Is Available

Geriatric evaluation is used in most state-funded and federally funded (Medicaid waiver) programs offering multiple services. The findings of a recent survey showed that 40 out of 42 identified Medicaid waiver programs require the use of a statewide standardized instrument for client evaluation.[4] Other publicly funded programs may also conduct assessments, but we know of no source of systematic information about them. Thus, geriatric evaluation is available and, in fact, required for most applicants to state-funded and medicaid waiver programs offering multiple services. However, it is important to note that the

[4]Congressional Research Service, Case Management Standards in State Community Based Care Programs (Washington, D.C.: 1993).

instruments in use at the state and local levels vary within and among states in terms of their contents and scope. Many instruments are designed to assess only an individual's needs in relation to the eligibility requirements of a program and to the services that it has to offer. These instruments may not provide a comprehensive evaluation of all the client's resources and needs.

We are planning to survey Medicaid waiver programs to learn more about the evaluation processes that they employ. We will compare their assessment instruments with the recommendations of experts regarding scope and intensiveness and investigate the role of these instruments in care planning. Our general aim is to determine how closely the actual use of geriatric assessment in these programs corresponds to its recommended use. We will report our findings from the survey at a later date.

The Professional Requirements for Those Who Administer Assessments

An evaluator's minimum professional requirements vary greatly in both Medicaid waiver programs and state-funded programs, typically involving some combination of education in selected fields (nursing, social work, social science) and related experience. Both the level of education and the length of experience vary from program to program. We do not know the

amount of training an evaluator for a particular program receives in the assessment instrument used by that program.

We found that there is no consensus among experts on the appropriate professional requirements for persons conducting a geriatric assessment. Some suggested a single professional--nurse or social worker--but others believed a team of professionals should be employed. One stressed that training is more important than discipline. All agreed that evaluators should be prepared to perform referral and other information-based services for clients, but several suggested that these services are not provided often enough. The investigation of evaluator training, especially as related to information, referral, and assistance services, is a part of the survey we are planning.

DISCUSSION

We know that the states are using assessment instruments in Medicaid waiver and state-funded home and community-based long-term care programs. We also know that the instruments vary with regard to scope, intensiveness, and personnel requirements, but we do not know the extent to which they vary. The problem with great variation is not only the fragmentation or redundancy of services and evaluations, as discussed earlier, but also the inability to learn something more generally about the common

needs and trends characterizing the elderly population in long-term care programs, as well as the availability or gaps in services characterizing the programs themselves. The proposed Health Security Act now calls for a uniform protocol of screening and assessment of clients' needs for its new home and community-based services program for individuals with disabilities. It may therefore be desirable to standardize the assessment process for all publicly funded home and community-based long-term care programs serving elderly persons, in all states, so that all applicants receive a comprehensive assessment of a specified scope and intensiveness, administered by an evaluator (or team) of specified background. It is important to note, however, that any attempt to standardize the process may result in an increase in its scope, intensiveness, and personnel requirements relative to what is currently found in some programs.[5]

Would Standardization Increase Equity?

In principle, having all elderly applicants for publicly funded home and community-based long-term care services undergo a relatively similar assessment, administered by evaluators with specified qualifications, would be a first step toward ensuring that scarce resources are distributed equitably. Standardization

[5]See, for example, G. J. Paveza et al., "A Brief Assessment Tool for Determining Eligibility and Need for Community-Based Long-Term Care Services," Behavior, Health, and Aging, 1 (1990), 121-32.

could not, of course, ensure that persons with the same needs would be treated similarly thereafter, but it would guarantee a comparable knowledge base for all clients. However, if applicants in some states and programs were more comprehensively evaluated than those in other places, then it is unlikely that equitable treatment would result. A client whose health, needs, and resources are less well assessed will tend to receive a less appropriate care plan, even when appropriate services are available.

Would Standardization Decrease Redundant Assessment?

Standardization promotes the use of the same or similar instruments in all programs. In such circumstances, it may be possible for a client already assessed when applying for one program to avoid a second assessment when applying for another. Standardization would not eliminate all second assessments, however. A second assessment would still be needed when considerable time has passed since the initial one or when the client's situation changes. Standardization may be a first step toward a community care system with a single entry point; as such, it would help decrease the fragmentation mentioned earlier. To the extent that one kind of geriatric evaluation can efficiently serve several programs, both programs and clients should benefit.

Would Standardization Promote Comprehensive Care Planning?

As noted, standardization would tend to make the geriatric assessment used in some programs more comprehensive than they now are. A comprehensive evaluation can promote the planning of program services by providing a broad overview of a client's situation, as well as meeting the client's nonprogram needs by pursuing vigorous information, referral, and assistance techniques. Care planning does not, however, follow inevitably from a comprehensive evaluation. A skillful clinical process is required to turn assessment scores or ratings into service recommendations. Professional requirements and training can help ensure that the translation from the comprehensive evaluation to a care plan is appropriate. Most important of all, standardization also promotes, relatively automatically, comprehensive care planning for the community as a whole by accumulating evidence regarding the needs--both met and unmet--of program clients.

Would Standardization Decrease Program Flexibility?

For many programs, the content evaluation is dictated by the specific program services offered. For these programs, standardization would decrease program flexibility to concentrate resources on its specific needs by wastefully increasing the scope of its assessment beyond that required for authorizing its

own set of services. It could further be argued that where a program offers only a single service, no assessment for the purpose of care planning is necessary, and where an array of services can be provided, an assessment designed only to determine the need for each would be required.

It should be noted, however, that only a comprehensive evaluation would allow the identification of all service needs, within or without a program, critical for maintaining an elderly person in the community. This use of assessment is similar to the use of the physical examination or check-up in traditional medical practice in that it is an attempt, perhaps the only attempt for many clients, to identify and possibly prevent conditions that are likely to cause difficulties in the future.

Another concern is that standardization could increase the resources devoted to assessment and thereby limit the time, money, and personnel available for the provision of services. It is true that standardization might result in an increased expenditure of professional time and money for programs that do not have adequate resources. However, assessment and services are related so intimately that neglecting one is likely to reduce the effectiveness of the other. Inadequate evaluation can only hurt service delivery. Further, the judicious use of screening instruments could ensure that only a portion of all applicants

would be targeted for comprehensive assessment, thereby reducing the proportion of resources required for evaluation.

Another potential limitation to program flexibility concerns the need of many programs to serve nonelderly people. Current publicly funded programs providing home and community-based long-term care to elderly persons also serve nonelderly disabled people; so will possible future programs. This may be seen as a further impediment to a standardized assessment for care planning. However, to the extent that the components of a comprehensive assessment needed for elderly clients are inappropriate for nonelderly ones and components needed for others are inappropriate for elderly persons, then the assessment process for such programs can preserve flexibility by using conditional mechanisms such as screening and skip patterns. Screening to determine eligibility and the need for comprehensive assessment is mentioned frequently, and skip patterns are rules of administration that make it possible to determine from a client's responses to certain questions which subsequent questions will be asked of that client. These mechanisms can help a program serving different categories of clients employ a common assessment process while avoiding the administration of assessment components that are inappropriate to particular categories of clients.

Finally, it has been stated that standardization may decrease program flexibility with respect to which professional groups should conduct geriatric evaluation and, of course, how they do it. Although there is no consensus among experts regarding personnel requirements, it is likely that standardization would lead to the establishment of some standards concerning the professional discipline, educational level, and amount of training with the assessment instrument. Establishing personnel requirements with respect to discipline and educational level within discipline may engender controversy regarding the need for routine input from a particular profession, such as nursing. The resolution of this issue might depend on whether it is decided that health assessment beyond self-report is necessary. Either way, it is helpful to consider the extent to which screening and specialized training may be employed in order to reduce the need for personnel with the most highly specialized training, who tend to be the most costly to the program and perhaps the most difficult to find in a particular locale. The training should also help staff appreciate the advantages of an instrument standardized not just for their program but across programs.

Would Standardization Alienate Clients?

It may be feared that a comprehensive assessment covering areas seemingly unrelated to the specific services a client seeks

will alienate and fatigue him or her because of its apparent irrelevance and extensiveness. Perhaps some clients perceive even minimal assessments as an imposition. As one expert put it, "no one comes to a program for assessment." Alienation and fatigue are serious problems. It is a challenge to design evaluation processes, including evaluator training in the nature of these problems, that enable most clients to avoid them. There is no reason to believe, however, that it cannot be done.

Alienation may be a particular problem when a client (or informal caregiver) appears to know just what is needed. It is not clear, however, that the most appropriate set of services, whether small or large, can always be arrived at without the benefit of a relatively comprehensive assessment, regardless of the client's or caregiver's initial opinion or, for that matter, the opinion of the intake staff of the agency or program. It may be that none of the participants in an evaluation have an adequate understanding of the client's current problems or likely future problems or the range of possible solutions, without the evaluation. It may be necessary to explain this to the client and caregiver. Also, as noted previously, the use of a screening instrument may enable staff to identify the clients whose problems are such that comprehensive assessment is not likely to be helpful.

SUMMARY

We found general agreement in the literature and among experts that a comprehensive, standardized geriatric evaluation is important and should be available to all elderly applicants for publicly funded home and community-based long-term care programs. We also found support for the use of a screen, as part of the evaluation process, by which to identify the clients who are most likely to benefit from comprehensive evaluation. Those so identified would receive the full assessment, preferably in their homes, to provide the basis for their care planning, including vigorous referral services.

We found that geriatric assessment instruments are employed in most Medicaid waiver and state-funded community care programs, but they vary across states and programs, and the extent of this variation is unknown. The professional and experience requirements for evaluators are well defined in these programs, but they also vary across states and programs, and we do not know what kind of training in the specific assessment instruments is provided.

An attempt to standardize the geriatric evaluation across programs has the advantages of increasing equity, decreasing the likelihood of redundant assessment, and promoting comprehensive care planning. However, it also has the potential to encroach upon program flexibility and to alienate some clients. If increased standardization is attempted, the use of screening and

improved training for evaluators might diminish the negative effects of inflexibility and alienation.

Madam Chairman, this concludes my remarks. I would be happy to answer any questions that you or members of the Committee may have.