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How Does Geriatric Care Management Affect Health Outcomes of Geriatric Patients in Hospitals

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**HOW DOES GERIATRIC CARE MANAGEMENT AFFECT HEALTH
OUTCOMES OF GERIATRIC PATIENTS IN HOSPITALS?**

BY

ELAINA R. TATE

**SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR
THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION**

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Advisor

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Abstract

The primary purpose of this study was to explore the private care model of Geriatric Care Management and how Mount Sinai Hospital's MACE program uses this model to meet the growing needs of geriatric patients. This exploratory study used in-depth interviews to collect data from Geriatric Care Management workers who serve geriatric patients. The interviews identified and explored various topics such as: professional qualifications, client needs, obstacles

and perspectives of Geriatric Care Managers. There are several findings that support the effectiveness of Geriatric Care Management in hospital settings. Because there is a growing need for services for the elderly population, further research should evaluate whether the current model of private Geriatric Care Management is appropriate and effective, or if communities should pursue alternate care models. By gaining more exposure and knowledge of the profession of Geriatric Care Management, practitioners and researchers can better understand its implications for serving a rapidly growing population.

How Does Geriatric Care Management Affect Health Outcomes of Geriatric Patients in Hospitals?

Chapter 1: Introduction:

According to the U.S. Census Bureau forum on aging, New York State is ranked third in the nation in population aged 55 years and older (Ball, Bruce & Montgomery, 2008). There is a critical need for improving geriatric care for patients aged 65 years and older. In 2000, it was estimated that 35 million people aged 65 years and older accounted for 13 % of the population in the United States (Ball, Bruce, & Montgomery, 2008). In 2011, the “baby boom” generation began to turn 65; consequently by 2050 it is projected that one in five people will be age 65 or older.

Hospitals and community health clinics are looking for ways to implement a geriatric care management system that can deliver effective quality healthcare at the same time reducing unnecessary cost. An effective process usually results in substantial cost savings for health providers as well as improved patient care and satisfaction. According to Golden, Ortiz and Wan (2013), in 2011, Medicare spending reached a cost of \$572 billion and is expected to grow by 20% annually through 2020. Potential avoidable hospitalizations and costly diagnoses are linked to caring for geriatric patients. Hottinger, Parker and Polich (2001) stated that on top of declining Medicare payment rates, many hospitals are faced with the prospect of an increased number of Medicare patients and the costs associated with caring for them. Moreover, funding sources and fragmentation of services make it problematic for geriatric patients and their families to obtain quality healthcare services. Consequently, geriatric care management has become extremely important in order to ensure that the increasing healthcare needs and costs of caring for geriatric patients are effectively managed and addressed.

There is a strong demand for acute care for elders units in hospitals as a form of geriatric care management to meet the needs of acutely ill geriatric patients (Parker and Polich, 2001). Geriatric care management programs can be beneficial to hospitals by preventing huge financial losses by focusing on high risk patients and costly diagnosis related groups. The role of a geriatric care manager is to work to reduce hospital stays, which will result in reducing hospital costs, and improve hospital operational and administrative efficiencies (Ball, Bruce, & Montgomery, 2008). A well designed geriatric care management system for hospitalized Medicare patients will ultimately enhance the mission of the hospital by increasing the quality of care provided. Moreover, there will be a sharp increase in patient and family satisfaction with better health outcomes (Shenkman, 2012). Geriatric care managers are “problem solvers,”

typically social workers or highly specialized trained nurses in the field of geriatrics. A geriatric care manager serves as a coordinator of ancillary resources to physicians to help enhance care and suggest alternative care setting procedures and solutions to problems (Golden; Ortiz; Wan, 2013). A geriatric care management system focuses on three functions: properly identifying patients in need of care management, intervention, and program performance evaluation. The goals of a geriatric care management system are to: Improve and better facilitate the patient's transition to alternative care setting; involve patients and families in decisions about their permanent care; and reduce the length of hospitalization of Medicare patients (Gerencher, 2012).

This study aims to investigate and explore the model of Geriatric Care Management implemented at Mount Sinai Hospital and how it compares with other hospitals that used similar care models. Because there is a growing need for care coordination services for the aging population, further research is needed to evaluate whether the current model of private Geriatric Care Management is appropriate and effective. Furthermore, based on the research findings, communities can decide whether to pursue alternate models and funding. The research will be designed to answer the following questions:

- 1. What has Mt. Sinai Hospital done to promote geriatric care management?**
- 2. How have health outcomes improved by implementing geriatric care management programs?**
- 3. How were the programs evaluated for effectiveness?**

Chapter 2: Literature Review:

Elderly patients in acute care hospitals are an area of great concern. Often, elderly patients present several disorders that can lead to significant functional impairment. These patients can manifest diminished physiologic reserve and a decreased capacity to adapt to unfamiliar surroundings. In response to dealing with the growing population of geriatric patients being admitted to acute care hospitals, specialized geriatric care inpatient - units should be created in hospitals to effectively care for geriatric patients and improve health outcomes. According to Buttar et al (2007), low-income seniors frequently have multiple chronic medical conditions for which they often fail to receive the recommended standard of care. Moreover, low-income

seniors represent a diverse and complex group of older adults who frequently suffer from low health literacy, chronic medical conditions and limited access to health care. Additionally, this group disproportionately accounts for a higher share of healthcare expenditures, including high rates of acute care utilization. In general, older adults often do not receive the recommended standard of care for preventive services and chronic disease management. Geriatric care management programs can be beneficial to hospitals by preventing huge financial losses caused by focusing on high risk patients and costly diagnosis-related groups.

During an episode of illness, geriatric patients receive care from many sources that are frequently not centralized or coordinated (Coleman et al, 2003). Consequently, the fragmented care can have negative outcomes which include: duplicated services, inappropriate or conflicting care recommendations, medication errors and even, in severe cases, death. Without proper coordination of care and services for geriatric patients in the transition from hospital to home, there will be higher cost of care due to rehospitalization and the use of the emergency department (Coleman et al, 2012). Patients with complex and chronic conditions should not endure fragmented care in a system filled with obstacles that make accessing care a nightmare. According to Barnes et al (2012) “Hospitalization often marks a critical transitional event for elderly people that may culminate in disability or death.” In the early 1990s, a new system of care for hospitalized geriatric patients called Acute Care for Elders was developed at the University Hospitals of Cleveland (Barnes et al, 2012). These programs provide effective geriatric evaluation, management, and assessment to address the needs of acutely ill geriatric patients from the moment they are admitted to the hospital (Barnes et al, 2012). Acute care for elder units deliver care from a team of healthcare providers, such as, geriatricians, pharmacists, advanced practice nurses, and physical therapists that are specially trained in caring for geriatric

patients with acute conditions. According to a case study done by Buttar, A et al (2007), the Indiana University–Purdue University at Indianapolis created a geriatric care assessment model called GRACE which stands for: The Geriatric Resources for Assessment and Care of Elders model. This model was developed specifically to improve primary care for low income seniors. This model builds on lessons learned from prior mistakes that were made when attempting to improve the care of older adults The GRACE model is based on a multidimensional assessment. According to Buttar et al (2007), the inpatient Acute Care for Elders (ACE) model was shown to be a cost-effective design to improve outcomes in hospitalized older patients by providing a geriatrics interdisciplinary team that integrates and enhances care delivered by the hospital attending physician.

“Unique features of the GRACE intervention compared with prior studies of home-based integrated geriatric care include the following: in-home assessment and care management provided by a nurse practitioner and social worker team; extensive use of specific care protocols for evaluation and management of common geriatric conditions; utilization of an integrated electronic medical record and a Web-based care management tracking tool; and integration with affiliated pharmacy, mental health, home health, and community-based and inpatient geriatric care services”(Buttar et al, 2007).

In the U.S., the delivery of acute and long term care to geriatric patients is fragmented and uncoordinated. Many times, services rendered fall under more than one agency, jurisdiction or provider. As described by Kodner & Kyriacou (2000), various components of the health system (i.e. home health, community, outpatient) work in parallel, with separate funding streams and budgets, under incongruent and frequently conflicting regulations and with different clinical roles, responsibilities and approaches. “The absence of a single community- based system or

institution with broad clinical and financial responsibility creates overlaps, leaves important needs unmet and is partly responsible for unnecessary hospitalization, institutionalization, less than optimum quality and poorly controlled costs”(Kodner & Kyriacou,2000). Treating chronic disease represents the highest cost and fastest growing segment of American health care. It has been estimated that these costs are 3 to 5 times higher than for non- chronically ill patients (Kodner & Kyriacou, 2000). Another barrier in implementing an effective geriatric care management system is developing a geriatric evaluation and management system to monitor and assess the quality of services rendered during transitional care. According to research done by Cohen et al (2002), comprehensive geriatric assessment for chronically ill geriatric patients dramatically improved survival and functioning status. Kodner & Kyriacou (2000), found that integrated care strategies that are properly assessed and evaluated for the care of frail geriatric patients offer the potential to improve quality outcomes and efficiency. In a system that is fragmented in funding, healthcare providers are challenged to develop comprehensive assessments that properly put together- service packages, monitor changes in health status and coordinate care from a perfusion of providers through periods of acuity, maintenance, rehabilitation and transition. Providers and patients must overcome many short comings found in our current healthcare system. Cohen et al (2002) conducted a trial study on how providing geriatric assessment and evaluations affected quality of life, survival and function of frail patients 65 years of age or older who were hospitalized at 11 Veterans Affairs medical centers.

“After their condition had been stabilized, patients were randomly assigned, according to a two-by-two factorial design, to receive either care in an inpatient geriatric unit or usual inpatient care, followed by either care at an outpatient geriatric clinic or usual outpatient care. The interventions involved teams that provided geriatric assessment and

management according to Veterans Affairs standards and published guidelines. The primary outcomes were survival and health-related quality of life, measured with the use of the Medical Outcomes Study 36-Item Short-Form General Health Survey (SF-36), one year after randomization. Secondary outcomes were the ability to perform activities of daily living, physical performance, utilization of health services, and costs” (Cohen et al, 2002).

Improvements in health-related quality of life were mixed and physical function outcomes did not differ between groups. Future studies are needed to determine whether more specific targeting will improve the program's effectiveness and whether reductions in acute care utilization will offset program costs.

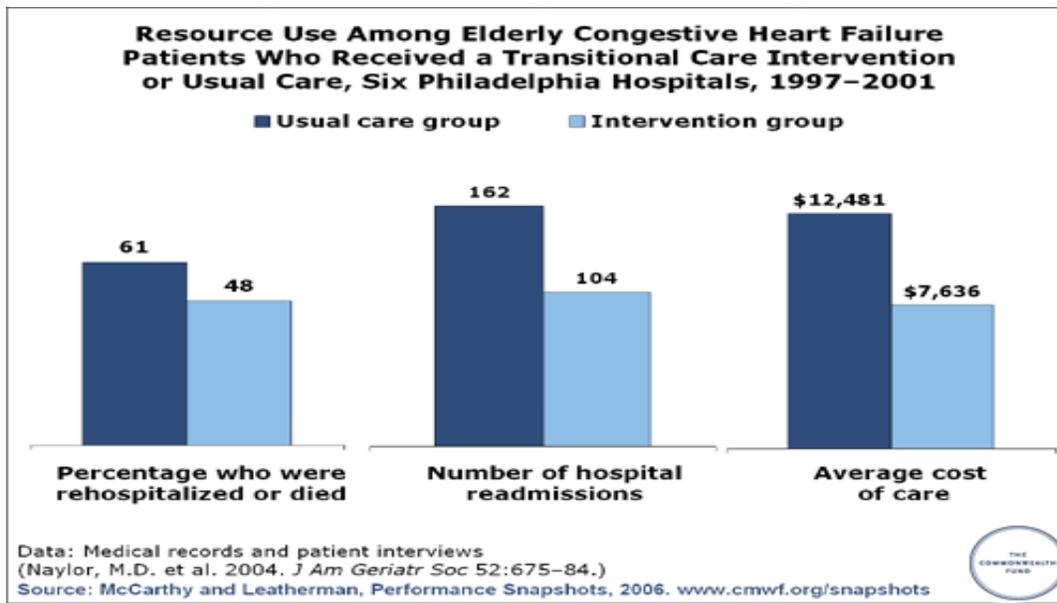
Limitations and other consideration

One barrier to implementing effective acute geriatric care units is the shortage of qualified medical staff who are properly trained in geriatrics and acute care for geriatric patients (Thomas, 2012). According to Harrington et al (2002), “In 2002 more than 35 million people were age 65 and older, and 23% of them reported poor or fair health. Additionally, elderly patients use 23% of ambulatory care visits and 48 % of hospital days, and they represent 83% of nursing facility residents.” Moreover, there is a strong need to have geriatricians to serve in the capacity of leaders on interdisciplinary teams and in institutions that have acute elder care units (Barnes et al, 2012).

Most healthcare providers do not receive adequate training in geriatrics. It has been reported that 58% of baccalaureate nursing programs do not have full-time faculty certified in geriatric nursing. Out of the nation’s 145 medical schools, only 3 have geriatrics departments,

and less than 10% of these schools require a geriatrics course (Harrington et al, 2012). Therefore, the amount and consistency of training remains limited. It can be argued that every health care provider should have some education in geriatrics and access to geriatric care experts. Coleman et al (2003) argued that "...effective intervention models are needed to improve geriatric interdisciplinary team care across settings." Transitional care is defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transferred between different locations and different levels of care within the same location." Because there is a financial incentive to discharge patients as quickly as possible, there is a strong need for assistance to ensure a smooth transition of geriatric patients from the hospital to a home environment in an efficient manner. Figure 1 below illustrates the effectiveness of transitional care of patients with congestive heart failure compared to patients with congestive heart failure that didn't receive transitional care.

Figure 1.



Empirical evidence gathered from focus groups with chronically ill geriatric patients and their caregivers was the basis for the design of an intervention model to help facilitate in transitional care (Coleman et al, 2003). Advance practice nurses trained in caring for geriatric patients with acute and chronic illnesses will assume responsibility for overseeing care across health settings to ensure geriatric patients’ needs are met. Once again, the problem lies in a shortage of advance practice nurses being adequately trained to care for geriatric patients with acute and chronic illnesses. A patient–centered intervention model was designed for use with geriatric patients with complex needs that require continuous management of both acute and chronic conditions (Coleman et al, 2003).

The ultimate goal of intervention is to improve transitions by providing patients and their caregivers with tools that will help them properly self-manage their conditions without the need for rehospitalization or further assistance from healthcare providers. According to Coleman et al (2003), intervention focuses on four conceptual areas: medication self-management, use of dynamic patient-centered record, primary care and specialist follow up, and knowledge of red

flags. These four pillars are designed to help educate and empower geriatric patients and their caregivers to meet their own healthcare needs and ensure continuity of care once discharged from the hospital. A transitional coach would function as a facilitator of interdisciplinary collaborations during the transitional care process. The background of a transitional coach would include: a geriatric nurse practitioner and a skilled RN trained in education and advocacy with elderly patients (Coleman et al, 2003).

The key elements of an effective geriatric care management system are: Identifying high risk patients as they are admitted for services, development of effective intervention models, and program performance evaluation to assess patients' outcomes. According to the aforementioned studies, Integrated and home-based geriatric care management can result in improved quality of care and reduced acute care utilization among a high-risk group.

Chapter 3: METHODOLOGY

This project will be an exploratory case study of the Mobile Geriatric Care unit in Mt Sinai Hospital, in New York City. Exploratory research is appropriate when problems have been identified but our understanding of them is quite limited. An exploratory design is appropriate for this study because the field of geriatric care management is relatively new and few studies have examined the effectiveness of geriatric care management in hospitals. This study design is qualitative in nature which allows a more diverse range of perspectives and generates new insights regarding this subject. The research will be designed to answer the following questions:

1. What has Mt. Sinai Hospital done to promote geriatric care management?

The interviews with the nurses and social workers working in the geriatric care management unit will be the primary source of the information for answering this question.

2. How have health outcomes improved by implementing geriatric care management programs?

Questionnaires given to healthcare workers will assess efficacy of current geriatric care programs that are in place.

3. How were the programs evaluated for effectiveness?

Interviews with geriatric care management team about their findings after completing program evaluations will be the primary source of the information for answering these questions.

Face-to-face interviews with the nurses and social workers in the geriatric care unit will be completed within a two-week period from the start of the study. The interviews with each participant will be limited to a maximum length of 15 minutes. Changes if needed will be made to the questionnaire before being given to healthcare workers that have direct or direct contact with geriatric patients.

The data regarding awareness of geriatric patients' needs will be collected via a questionnaire and survey that will be given to the Geriatric Care Manager or Supervisor that oversees the geriatric care management team that work in the geriatric care unit. The interviewer will ask questions about: the participant's experience working with geriatric patients, policies and procedures in dealing with geriatric care management and best practices for assessment evaluation of existing programs. The data will be collected to determine the answers to the following questions:

1. What are the needs of geriatric patients?

2. What are the programs and procedures to meet the needs of the patients?

3. Are these programs and procedures effective?

Sampling Procedures

The sample of this study is limited to the staff of the Mobile Geriatric Care Unit at Mount Sinai Hospital in New York City. Each participant was initially contacted by email and phone to determine if he or she were willing to participate in the study. The response was positive and a date and time for a face-to-face interview with participants. Before the interviews, the informed consent form was discussed and then emailed to the participant for review. Additionally, survey questions via Survey Monkey were also emailed to the Geriatric Care Manager. After the interview, each participant was asked for names and contact information of other Geriatric Care Managers in the New York City area who may be interested in participating in the study.

The data for this study was collected during a face-to-face interview with a pen and notepad. The participants did not feel comfortable being recorded on an audio recording device. After the interviews, the answers to the interview questions were entered into a Word document. Only one interviewer conducted all the interviews. The instruments used in this study included: a 7-question interview guide, a 7-question survey which are included in the Appendices and a participant consent form (Appendix A). The interview guide is composed of a range of questions about the professional background, services, and clients that Mobile Geriatric Care unit serves.

Protection of Privacy

This study was determined “exempt” under federal regulations of the FDA because the interview participants are social service professionals being interviewed about the model and services of their professional practice; thus, there is little to zero risk of economic, psychological or social harm. The participants’ rights to privacy were protected in many ways. First, an

informed consent form notified the participant about the nature of the interview questions in advance of the interview. All participants had the right to refuse to be interviewed as noted on the informed consent form. The participants also had the right to refuse to be recorded. Until the collected data was destroyed, transcribed data was securely stored on the password-encrypted personal computer of the researcher. Lastly, the researcher was the only person to interview the participants and the only person to analyze the data. Personal identifiers such as: Name, contact information or job titles were not recorded in any way as they were not essential to the study.

Limitations

This study explored the practices and perspectives of a very small number of Geriatric Care management workers at Mount Sinai Hospital. Due to the nature of their work only two participants were available for interviews. There was zero response to the survey sent out to the participants of the study. Due to the exploratory nature of the research design, the findings cannot be generalized to the large network of Geriatric Care Managers and private Geriatric care management models used at other facilities.

Chapter 4: Findings

The purpose of this case study was to explore how different models of geriatric care management (GCM) affected health outcomes of geriatric patients in hospitals. Information was collected about professional education and credentials, goals of GCM services, funding sources and common resources. The in-depth interviews included 7 open-ended questions as well as clarification questions which allowed the participants to expand on specific topics of interest. The purpose of the interview questions was not to measure the similarities of the Geriatric Care Managers in an agency, but rather to show the diverse ideas and practices of how Geriatric Care Managers respond to the needs of their geriatric patients that may be unknown to researchers in this field. Nevertheless, the following section describes the participants' answers to each question, with similarities noted where appropriate.

The Purpose of Geriatric Care Management

Both participants described the purpose of Geriatric care management (GCM) in very similar terms. Both described GCM as services that help elderly clients remain independent and live with dignity for as long as possible. This could be interpreted to mean helping clients stay out of long term care facilities like nursing homes. One participant stated, "The objective of

Geriatric Care Management helps our clients live independent as long as possible.” Another participant stated, “I am an advocate for the medically frail and elderly to ensure they have access to the appropriate resources that will help them have a life of quality and dignity. I also help families navigate through this complex healthcare system to ensure their loved one gets the proper care to meet their needs.” Working in the same organization it was expected that both participants would have similar definitions of what Geriatric Care Management is.

Types of Clients

Both participants work with older adults over 75 with chronic and acute illnesses. Both participants also stated that they work with clients whose family members are care givers and primary decision makers for the clients’ healthcare decisions. A participant estimated that approximately 20% of their clients were over the age of 85. Another participant said that about 60% of their caseload is made up of minorities and low income elderly patients from surrounding neighborhoods. “The majority of the elderly population that needs GCM are staying at home and being cared for by family members.” Because the client is often hesitant to seek GCM services, it is usually concerned family members that request services on the client’s behalf. This can cause some conflict, as stated by one participant, because sometimes concerns of the client may differ from the families’ concerns.

Client Needs

Both participants had different common needs of clients. Nevertheless, some of the frequently mentioned needs included: inpatient care, caregiver support, home health care resources, and long term care and medication management. As one participant reported, “Most clients come to me when they are in crisis and don’t know where to turn for resources.” Another

participant noted that it's usually when a client received a life-changing illness that requires resources that they can't access on their own as their reason to seek GCM services.

Obstacles

The biggest obstacle encountered by both participants was communication issues and family dynamics. Because caring for an ill loved one is a stressful time, the client and family member are not always in agreement when it comes to treatment plans and prognosis of illness. Another factor is how a family's culture and religion plays a major role in planning for the client's care. A participant stated that lack of finances can be an obstacle for clients that need long term care once discharged from the hospital. Not all elderly patients qualify for Medicaid or have long term care insurance. This forces family members to be care givers for the client. "Finances are generally the cause of most arguments amongst family members."

Care Model

Mount Sani uses the Mobile Acute Care of the Elderly (MACE) model, which involves a team which consists of: a geriatrician-hospitalist, a geriatric medicine fellow, a social worker, and a nurse specialist. This team meets daily to discuss care, with the nurse specialist serving as a coach. A participant mentioned that "...working with an interdisciplinary team of health professionals helps provide the best care possible for the client." Another participant mentioned that the care team meets daily at 8:00 in the morning to create care plans for patients assigned to their unit.

Effectiveness of Care model

According to an independent study done by Hung (2013), "admission to the MACE service was associated with lower rates of adverse events, shorter hospital stays, and better satisfaction. This model has the potential to improve care outcomes among hospitalized older adults." As noted by one participant, "... readmission of clients within 30 days of discharge is very low." Another participant commented on the high level of patient satisfaction which is measured by customer satisfaction surveys given to clients when discharged. The participant also estimated an 85% satisfaction rate among their clients.

Future of GCM

When asked about the future of the Geriatric Care Management profession, both participants had different responses. One participant stated, "With all the advances in technology and people living longer, I see GCM helping elderly live longer with a better quality of life." The participant also added that because of the rapidly growing geriatric population, there will be more community resources available for elderly clients in need. Another participant stated that "Because of the Affordable Care Act, more people will pursue careers in healthcare being trained in geriatrics and more healthcare professionals will become Geriatric Care Managers." Both participants were optimistic about future funding for geriatric care services.

Analysis of Findings

There are 2 major geriatric care models that are used in hospitals. Mobile Acute Care of the Elderly (MACE) and Acute Care for Elders (ACE) program. According to a study by Hung (2013), using data on patients treated at Mount Sinai, researchers compared outcomes for the

MACE patients with patients who received care from a usual care team that did not include a nurse specialist or a geriatrician. Researchers found that the MACE program shortened hospital stays and significantly reduced adverse events. However, the MACE system did not significantly reduce 30-day readmissions. Unlike MACE that focuses on treating a variety of chronic and acute illness of geriatric patients, the ACE model focuses on geriatric screenings, specific care of specific illnesses.

“In one study, UAB researchers assessed the Acute Care for Elders (ACE) program, in which a coordinated team of practitioners—including geriatricians, nurses, dietitians, social workers and physical therapists—conducted geriatric screenings and focused on geriatric-specific symptoms” (The Advisory Board Company, 2013)

Specifically, the researchers studied over 800 geriatric patients in 25 common diagnosis-related groups who received treatment. Researchers then compared outcomes for patients participating in the ACE program and patients receiving usual care from a coordinated team of practitioners. It was found that patients participating in the ACE program cost less and were less likely to be readmitted to the hospital. It is critical to identify models that deliver higher care to geriatric patients without escalating healthcare costs. There are more geriatric patients with multimorbidity and complex illness, yet there are fewer resources to care for these patients.

Kaiser Permanente produced a study on the effectiveness of their GCM program in the managed care setting. The study tested whether geriatric care management plus purchase of service (POS) intervention lower medical costs, improve satisfaction of care for Permanente members aged 65 and older (Enguidanos et al., 2003) Health outcomes overall were improved for the majority of Permanente members aged 65 and older that were enrolled in the study. From the studies done

on care models, it is evident that geriatric care management is an effective tool to improve health outcome of geriatric patients.

Chapter 5: Conclusion

There is a critical need for improving geriatric care for patients aged 65 years and older. This segment of the population is growing at a steady fast pace. Currently our healthcare system is not designed to keep up with the growing demands of such a large geriatric patient population. Only a small percentage of healthcare providers are adequately trained to care for geriatric patients with acute and chronic illnesses. A fragmented uncoordinated system has resulted in patients' healthcare needs not being met which results in increased health care costs and a declining

quality of life for geriatric patients. It has been found that acute and chronically ill geriatric patients benefit the most from geriatric care management (Gill et al, 2002). This case study shows that, when implemented correctly, geriatric care management can be very beneficial in: reducing length of hospital stays, cutting Medicare costs and provide better quality of care to geriatric patients.

Recommendations

Treating the geriatric patients requires a high level of coordination of care, but the healthcare system typically does not provide the resources to allow even the best doctors to do so. The rapidly growing number of geriatric patients with chronic diseases will cost billions of dollars in healthcare costs. Treating geriatric patients is challenging even for the most skilled physician. As a result of a growing aging population, changing demographics and a growing need for long term care, there is an increasing demand for new and up-to-date empirical evidence of the efficiency and cost-effectiveness of alternative long term care approaches and practices (Feldman and Kane, 2003). An effort to make long term care systems more efficient and effective in providing care to patients that utilize the care the most - acute and chronically ill geriatric patients, will require that researchers play a more significant role in informing service delivery. As argued by Feldman and Kane (2003), researchers as well as practitioners should come up with appropriate topics that need to be tested to see what works and what doesn't as it affects delivery of healthcare to geriatric patients. Future research should both respond to and push forward the field of practice. Furthermore, researchers can help improve patient outcomes by performing ongoing research on best practices for program performance evaluation models. Current evaluation models that are relevant today may not be relevant 10 years from now. It's

critical to have up-to-date research that is keeping pace with current trends in geriatric care management. Researchers are essential in this capacity.

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Appendices

Appendix A.

Consent to Participate in Research

How Does Geriatric Care Management Affect Health Outcomes of Geriatric Patients in Hospitals?

Purpose: You are being asked to participate in a research study, which will be conducted by Elaina Tate, a student in Public Administration at Pace University. The study will explore the services and models of Geriatric Care Management at Mount Sinai Hospital in New York City.

Research Procedures: You will be asked several questions by the researcher about your professional background, the services you provide to clients, and other aspects of your agency. The interview may require up to fifteen minutes of your time.

Risks: There are no known risks to the questions in the interview. You are free, however, to decline to answer any questions you do not wish to answer or to stop the discussion at any time.

Benefits: You may gain additional insight about geriatric care management and elderly services, or you may not personally benefit from participating in this research. It is hoped that the results of the study will be beneficial for both students and practitioners who work with the elderly population.

Confidentiality: Your responses on the questions will be anonymous to everyone except the researcher who will conduct the interview. Personal identifiers such as name, contact

information, or business/agency name will not be recorded. With your permission, the interview will be audio taped. Those recordings will be permanently deleted as soon as the discussions have been transcribed, and in any event no later than one year after they were made. Until that time, they will be stored in a secure location.

You will not receive any compensation for participating in this study.

If you have any questions about this research, you may contact Elaina Tate at (832) 334-3755 or by e-mail at **elainatate@gmail.com**.

Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page and agree to participate in the research.

Signature of Participant

Date

Appendix B.

Glossary

ADLs

“Activities of daily living” which include routine daily activities such as eating, bathing, dressing, toileting, and transferring.

Assisted living homes/facilities

A residential facility that combines: housing, custodial care services and health-care services. Assisted living residents are too frail to live alone, but too healthy to live in a skilled nursing facility.

Older adults

Adults who are age 65 years and older.

Geriatric Care Management (GCM):

A specialized field of professional care managers who provide: assessment, planning, coordinating, and monitoring for older adults and their families. These services are often provided by professionals such as social workers, nurses, or gerontologists who help older adults maintain a highest possible quality of life as they age.

IADLs

Instrumental activities of daily living that are not as basic as ADLs, but allow persons to function

independently in a community. IADLs may include managing money, housekeeping, managing medications, shopping or cooking

Medicare

A national health insurance program which guarantees access for people with disabilities and adults over the age 65.

Medicaid

A federal and state-funded health program for low-income individuals.

NAPGCM

The National Association of Professional Geriatric Care Managers, which is a professional organization advancing the interests of Geriatric Care Management.

Skilled nursing Facilities/ Nursing Homes

A residential facility that provides housing and health care services that are less acute than at a hospital, but more acute than an assisted living facility. Many skilled nursing facilities provide both long-term care (LTC) and short-term rehabilitation care such as physical and occupational therapies.

Appendix C.

Capstone Interview Questions Template

Background: This paper will identify rather the current private models of geriatric care management improve health outcomes of geriatric patients in hospitals. The research will focus specifically on how Mt. Sinai Hospital's private model of geriatric care management compares with other hospitals that used similar models to delivery care to their geriatric patients.

1. How would you define Geriatric Care Management?
2. What types of clients do you serve?
3. What are your clients' most common needs or concerns?
4. What services does your organization provide to clients?
5. What type of geriatric care model does your organization use?
6. How is your model of care effective in treating your clients?
7. Looking forward, what do you see as the future of the profession of Geriatric Care Management?

Appendix D.

Survey Questions

1. Did you receive special training in Geriatric Care Management?
2. How long have you worked in Geriatric Care Management?
3. What type of clientele does your organization typically serve?
4. What services does your organization provides?
5. What type of comprehensive assessment model does your organization use?
6. What type of criteria does your organization use to identify patients who are likely to benefit from comprehensive geriatric assessment?
7. What criteria does your organization use to identify vulnerable patients post- hospital discharge?

