of the problem and the structure of the setting. Other key members of the care team include social workers, pharmacists, psychologists, and physical and occupational therapists. Most assessments discussed in this chapter can be performed in outpatient settings, including functional assessments, cognitive and mood screening, gait and balance assessment, medication review, eye and ear examinations, and continence evaluations. Interview of a caregiver can augment the information collected. Care in this setting can be complicated, though, by problems with transportation and ineffective or inefficient communication among multiple providers, particularly for patients with multiple specialists.

Over the last several years, home care has reemerged as an effective means of providing health care for older adults. As with the outpatient setting, Medicare Part B will reimburse providers in part for services rendered in the home. In addition, if a rehabilitative or skilled service is needed, Medicare Part A provides coverage. Patients receiving services in the home must be "homebound," implying that they are significantly functionally impaired and travel with assistance out of the home infrequently and usually only for medical purposes. Services rendered in the home include a full range of evaluations by teams of providers from a variety of health professions depending on needs. Social workers often lead these visits and perform case management, assessing financial and other resource needs. Nurses, clinical nurse specialists, and/or nurse practitioners provide skilled services when necessary, including health education, symptom monitoring, or wound care. Physical and occupational therapy can assess mobility and home safety and greatly enhance function and independence. Furthermore, examination of a person's home environment can reveal much about his or her safety and nutrition, and can facilitate education or intervention in these areas. Physicians may serve as medical directors of such programs, but may also perform visits themselves to learn more about a given patient's health status. If significant concerns exist about a patient's safety, particularly in the setting of cognitive impairment, a home visit may provide information about the need for more urgent interventions, including referrals to Adult Protective Services. Research has demonstrated that coordinated home care programs can improve management of chronic disease, including dementia, diabetes mellitus, and congestive heart failure, as well as to reduce rehospitalization in patients with congestive heart failure.

Long-Term Care

The phrase *long-term care* describes the array of services available to provide care for patients with disability from chronic and acute conditions. This definition includes the services offered in the outpatient and home settings described previously. Most associate the term, however, with the system of nursing facilities providing personal and medical care for disabled adults of all ages. Skilled nursing facilities provide long-term care for those with permanent disabilities from chronic illness or short rehabilitative stays after acute illness (e.g., stroke) or procedures (e.g., joint replacement). The scope of services may also include end-of-life care in conjunction with a hospice care team. Facility staff includes licensed nurses who give 24-hour supervision, with much of the personal care provided by certified nursing assistants. Each facility also has a medical director overseeing various aspects of medical care. An attending physician, who may or may not be the medical director, performs patient visits every 30 to 60 days. Most SNFs also employ physical, occupational, and speech therapists for rehabilitation care, dietitians, social workers, and recreational therapists. Patients with moderate or severe dementia constitute approximately 60% of patients living in skilled nursing facilities. Although Medicare Part A provides payment for rehabilitative stays of 100 days or less (with a copayment for days 21 to 100), it does not finance long-term stays. Such patients pay out of pocket, through long-term care insurance, or through Medicaid, a joint federal and state assistance program. Medicaid constitutes 47% of all payment sources for skilled nursing facilitie care.

For patients with less complex care needs, assisted living facilities or domiciliary care homes provide an alternative arrangement for long-term care. Although these facilities vary dramatically in their size and structure, most provide nonskilled care for patients who need some assistance with activities of daily living. Licensed nurses may be present during some specified periods of time, and other professions may visit the facility intermittently to provide services such as physical therapy. Facilities do not have medical directors, and patients normally continue to see a primary care provider in the outpatient setting. Unlicensed staff, including nursing aides, provides most of the personal care and assistance. Medicaid provides some reimbursement for this type of care, but the majority of residents pay out of pocket or through other assistance programs, such as Social Security. For those with adequate means, a living option has emerged that combines independent living, assisted living and skilled care in one location. Continuing care retirement communities allow residents to live within the same community while moving through or between levels of care. They offer residents convenient central resources, such as recreational and dining facilities, transportation, and onsite health care.

PACE

In the 1970s, a group providing care for older Chinese adults in San Francisco developed a model of long-term care centered in the community. Proponents of this model, entitled the Program of All-inclusive Care for the Elderly (PACE), believed that the community (rather than the institution) provided a better location to meet the chronic care needs of older adults. From its start as a community-based effort in California, the PACE model has grown with the support of private foundations and Medicare demonstration projects; now PACE is a benefit for elders who qualify for both Medicare and Medicaid. Reimbursement is at 95% of the cost of nursing home care in the area where the patient lives. Participants must be over 55 and certified by the state to be eligible for nursing home care. The PACE program then uses combined Medicare and Medicaid funds otherwise slated to pay for the individual's long-term care to provide care in the community; much of it coordinated through senior centers offering an array of resources and services, including the following*:

- Adult day care, offering nursing; physical, occupational, and recreational therapies; meals; nutritional counseling; social work; and personal care

*Information from the National PACE Association website at www.npaonline.org.