TABLE 11-5 CARE SETTINGS FOR OLDER PATIENTS

Setting	Services	Payment Source
Hospital acute care	Medical, surgical, and psychiatric services that cannot be provided in less complex settings	Medicare, Medicaid, and private insurance
Emergency room	Resuscitation, stabilization, triage, disposition	Medicare, Medicaid, and private insurance
Inpatient rehabilitation	Hospital-based residential program providing team-based, physician-supervised, intensive therapeutic rehabilitation for specific diagnoses	Medicare, Medicaid, and private insurance
Outpatient clinic	Chronic, urgent, and preventive services	Medicare, Medicaid, and private insurance
Postacute care	Medical, nursing, and rehabilitative services after hospitalization, often based in hospitals or nursing homes	Medicare up to 100 days with eligibility requirements
Long-term care	Residential program with daily nursing and aide care for persons who are dependent in self-care	Medicaid, private payment, long-term care insurance
Assisted living	Residential program with daily aide care and housing for persons who are dependent in household management	Private payment
Home health care	Nursing and rehabilitative services for episodes of care provided to persons in the community	Medicare, Medicaid
Day programs	Supervised settings providing nursing and aide care for scheduled hours	Private payment, Medicaid

Care of the Elderly (PACE) model. In this situation, older adults who are eligible for both Medicare and Medicaid and who are otherwise eligible for chronic nursing-home care can receive coordinated medical and functional services in conjunction with a day-care program.

For most older adults, a caregiver must be available to provide assistance on weeknights and weekends. Under current policy, home health services do not provide chronic functional assistance in the home but rather are targeted at episodes of care supplied by medical or rehabilitative services for older adults who are considered home bound. Some community agencies, whether private or public, can provide homemaker and home aide services to assist the home-bound older adult with functional needs, but there may be income requirements or expensive private payment may be needed.

Within the past decade, there has been tremendous growth in a broad spectrum of assisted-living settings. Such settings do not offer the degree of 24-h nursing supervision or personal aide care that is provided in traditional nursing homes, although distinctions are becoming blurred. Most assisted-living settings provide meals, medication supervision, and homemaking services, but they often require that residents be capable of transporting themselves to a congregate meal site. Moreover, most of these settings accept only private payment from residents and their families and thus are hard to access for older adults with limited resources. Some states are exploring coverage for lower-cost residential-care services such as family care homes.

Models of Care Coordination The complexity and fragmentation of care for older adults results in both increased costs and increased risk of iatrogenic complications such as missed diagnoses, adverse medication events, further worsening of function, and even death. These serious consequences have led to a strong interest in care coordination through teams of providers, with the goals to reduce unnecessary costs and to prevent adverse events. Table 11-6 lists examples of evidence-based models of care coordination that were recommended in a 2009

TABLE 11-6 EVIDENCE-BASED MODELS OF CARE COORDINATION FOR OLDER PATIENTS (INSTITUTE OF MEDICINE, 2009)

Model	Team Members	Services
Interdisciplinary primary care "medical home"	Primary care physician plus social worker, nurse, nurse practitioner, or other care coordinators	Coordination of medical and social needs across settings
Case management	Nurse or social worker	Education of and information dissemination to patients and families; in some cases, communication with providers and settings
Disease management	Nurse	Health education and follow-up support for specific chronic diseases
Preventive home visits	Physician, nurse, social worker, and others	Structured assessment of physical, mental, functional, and social status in the home setting, with recommendations for care and prevention
Comprehensive outpatient geriatric assessment and management	Physician, nurse, social worker, and sometimes others (e.g., pharmacist, rehabilitation therapist, psychologist)	Structured assessment of physical, mental, functional, and social status in the outpatient setting, with recommendations for care and prevention. Some programs also take responsibility for implementing the recommendations.
Pharmaceutical care management	Pharmacist	Review and recommendations, in any setting, regarding the total medication regimen
Chronic disease self-management	Nurse, health educator, or other health professional	Health education and coaching for specific chronic conditions
Prevention rehabilitation	Rehabilitation therapist	Anticipatory evaluation, therapeutic exercise, and assistive technology in the home or outpatient setting for older adults with physical disability
Caregiver services	Social worker, psychologist, or other health professional	Education, counseling, and resource referral for caregivers of older adults with chronic functional and mental health problems
Hospital discharge/ transition coordination	Nurse, nurse practitioner	Care planning and education for patient and family before and after hospital discharge
Hospital at home	Physician, nurse, pharmacist	Diagnostic testing and medical treatments that can replace hospitalization or reduce length of hospital stay for target conditions
Nursing home care coordination	Nurse practitioner or physician assistant	Scheduled assessment and care planning as well as education for health workers in chronic-care settings
Hospital delirium comprehensive care	Physician, nurse	Prevention, screening, and management of delirium in the hospital setting
Comprehensive inpatient geriatric assessment and management	Physician, nurse, social worker, and sometimes others (e.g., pharmacist, rehabilitation therapist, psychologist)	Specialized inpatient settings such as acute care of the elderly (ACE) units or roving multidisciplinary teams that provide evaluation and recommendations for medical, mental health, functional, and social needs. ACE units and some teams take responsibility for implementation of recommendations.

Source: Reproduced with permission from C Boult et al: J Am Geriatr Soc 57:2328, 2009.