

GERIATRIC AMBULATORY CARE

- 1. PURPOSE.** This Veterans Health Administration (VHA) Handbook describes an array of options for providing outpatient geriatric care to Veterans.
- 2. SUMMARY OF MAJOR CHANGES.** This is a new Handbook defining options for geriatric outpatient care.
- 3. RELATED ISSUES.** VHA Handbook 1140.01, VHA Handbook 1140.07, VHA Handbook 1140.09, and VHA Handbook 1141.04.
- 4. FOLLOW-UP RESPONSIBILITIES.** The Chief Consultant for Geriatrics and Extended Care (114), within the Office of Patient Care Services (11) is responsible for the contents of this Handbook. Questions may be addressed to 202-461-6750.
- 5. RESCISSION.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of April 2015.

Robert A. Petzel, M.D.
Under Secretary for Health

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CONTENTS

GERIATRIC AMBULATORY CARE

PARAGRAPH	PAGE
1. Purpose	1
2. Background	1
3. Definitions	2
4. Required Geriatric Ambulatory Care Services	4
5. Goals	5
6. Responsibilities of the Facility Chief of Staff	5
7. Responsibilities of the Facility Chief, Primary Care	5
8. Responsibilities of the Associate Chief of Staff for Extended Care	5
9. Target Population	6
10. Workload Reporting	6
11. Quality Assurance	7
APPENDIX	
A Relationships Among and Between Primary Care, Geriatric Consultation, Geriatric Primary Care, and Geriatric Evaluation and Management (GEM) Clinic	A-1

GERIATRIC AMBULATORY CARE

1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the distinctions between and transitions among a set of clinical programs providing outpatient geriatric care to Veterans.

2. BACKGROUND

a. Public Law 106-117, “The Millennium Act,” authorized VHA to expand access to non-institutional alternatives to long-term care. As intended, during the first decade of the new millennium, an unprecedented number of Veterans of advanced age are able to remain in their homes and communities despite significant health care needs. Many of these Veterans receive Department of Veterans Affairs (VA) Medical Center-based outpatient services. In fiscal year (FY) 2008, 52.2 percent of the 3.8 million Veterans receiving primary care in VA were age 65 or older. In addition to their multiple medical problems, many had functional and cognitive impairments: conditions that dramatically increase in prevalence and severity with age and markedly impact patient care. Veterans over the age of 85, the fastest growing component of VHA’s target group, represent the most cognitively and physically disabled subset of the elderly Veteran population, with over half either having a diagnosis of a dementing illness or requiring daily assistance in self-care.

b. At a time of unprecedented growth in demand for service by elderly Veterans, the supply of providers trained in geriatrics is markedly inadequate. An April 2008 Institute of Medicine (IOM) report entitled “Retooling the Health Care Workforce for an Aging America” documents this shortage, which is expected to worsen if present trends continue in physician specialty selection. There are currently over 7,000 primary care providers in VA managing approximately 5 million primary care patients, for an overall ratio of about 714 patients per provider. Yet in 2008, IOM reported the national ratio of geriatricians to the over 65 population as 1:4,000—less than a sixth of the primary care ratio. Recent estimates by the Office of Geriatrics and Extended Care indicate a similar ratio in VHA, where patients of advanced age, on average, are more complex and impaired than their age-matched counterparts in the non-VA sector. Therefore most VA care for elderly Veterans is being provided by primary care providers with no specialized training in geriatrics. In 2008, about two million Veterans receiving outpatient care in VHA were 65 or over. Of these, only about 74,000 (approximately 3.7 percent) were seen at least once in a geriatric medicine clinic and about 33,000 (1.7 percent) received their primary care exclusively in those settings. The remainder of this age group (94.6 percent) received their primary care management exclusively in primary care clinics.

c. The demand for geriatric expertise, combined with the present and projected undersupply of trained geriatricians, has resulted in a unique blend of generalist and specialist roles for VHA geriatric providers:

(1) Providing longitudinal primary care to the most frail and complex Veterans (see VHA Handbook 1140.07), and those who are homebound (see VHA Handbook 1140.01).

(2) Offering consultation to VA primary care colleagues on selected patients with geriatric issues so that these patients can continue under the care of their primary providers. This latter role increases access to the geriatric provider and allows greater diffusion of geriatric knowledge beyond what would be possible if all VA geriatric expertise were devoted exclusively to the longitudinal care of elderly Veterans. This geriatric consultation role may be fulfilled in any of three ways, dependent on the services and expertise available:

(a) Consultation to a specific geriatric consultation service or clinic, as described in VHA Handbook 1140.09;

(b) Consultation to Geriatric Primary Care, as described in VHA Handbook 1140.07 and VHA Handbook 1140.08; and

(c) Consultation to a Geriatric Evaluation and Management (GEM) clinic, as described in VHA Handbook 1140.4.

d. The interplay of these roles, among themselves and with primary care providers, is dependent on the actual expertise and programs offered at a given site, and is schematically pictured in Appendix A. The diagram specifies that the decision to consult, co-manage, or transfer care is a decision made by the Primary Care Provider (PCP) in accordance with the provider agreement that is in effect between Primary Care and Geriatrics.

3. DEFINITIONS

a. **Geriatric PCP.** A Geriatric PCP is a physician, physician assistant, or nurse practitioner with training or certification or with extensive, supervised clinical experience in the management of patients of advanced age with chronic disease compounded by psychosocial and functional issues, in collaborative partnership with an interdisciplinary team of suitably prepared health care professionals.

b. **Comprehensive Geriatric Assessment (CGA).** A CGA is the collection and documentation of objective physical, functional, physiological, psychosocial (including family or formal or informal caregiver situation), pharmacological (including assessment of polypharmaceutical regimen), and historical health-related information in addition to subjective information on patient preferences, goals, and expectations that leads to and forms the basis of the interdisciplinary plan of care. CGAs are performed for patients affected by multiple chronic diseases of the sort characteristically encountered in persons of advanced age made more complex by one or more functional or psychosocial factors. A CGA is performed by an interdisciplinary team customarily consisting, at a minimum, of a physician or other independent licensed provider with advanced clinical training or certification in geriatrics (e.g., suitably trained physician assistant or nurse practitioner), a nurse, and a social worker or other associated health professional. The process of a CGA followed by development of the interdisciplinary plan of care is termed a “geriatric evaluation” and constitutes the geriatric evaluation component (see subpar. 3g) of a GEM Program.

c. **Primary Care.** Primary Care is the provision of integrated, accessible health care services by clinicians accountable for addressing a large majority of personal health care needs,

developing a sustained partnership with patients, and practicing in the context of family and community.

d. **Home-based Primary Care (HBPC).** HBPC is comprehensive, longitudinal primary care provided in the Veteran's residence by a physician-supervised interdisciplinary team of VA staff who manage complex, chronic, disabling diseases when routine clinic-based care is not feasible (see VHA Handbook 1140.01). Because the initial stage of HBPC consists of an extensive, systematic assessment of a patient's health, function, and environment, followed by development of an interdisciplinary plan of care, each new admission to HBPC counts for workload purposes, as "geriatric evaluation;" although the S0250 code should not be used in this particular case (see subpar. 10g(4)).

e. **Geriatric Primary Care (GPC).** GPC is the integrated longitudinal management of the health care needs of elderly outpatients by a Geriatric PCP. GPC is provided to older patients with a range of needs. At one end of this spectrum are those relatively healthy seniors who desire the services of a provider whose professional interests are focused exclusively on care of older adults. At the other end of the spectrum are the most frail, complex, and challenging elderly patients who require a primary care provider with specialized clinical expertise plus familiarity with the range of community services, involvement of family or other caregivers, and other support mechanisms necessary to provide integrated care to those of advanced age whose lives are marked by coexisting functional, social, cognitive, and medical problems. The limited supply of trained geriatric care personnel in VHA dictates that most GPC activity in VA needs to concentrate on Veterans closer to the latter end of the scale. Although at some stations the GPC clinic may be informally called the "Geriatric Clinic," this practice has the potential for causing confusion when entering workload or tallying information for performance measures, and is to be avoided if possible. *NOTE: For VHA geriatric primary care provision and details of other considerations of the service see VHA Handbook 1140.07.*

f. **Geriatric Consultation.** Geriatric Consultation is the time-limited, problem-focused assessment of an inpatient or an outpatient by a physician or other independent provider with advanced training, certification, or extensive experience in geriatrics in response to a request for clinical advice on a specific clinical geriatric issue (see VHA Handbook 1140.09).

g. **GEM.** GEM is a specialized program of services provided by an interdisciplinary team of health care professionals in either an inpatient or outpatient setting on behalf of a group of older patients who are most likely to benefit from the service (see VHA Handbook 1140.4). The two components of GEM are:

(1) **The Geriatric Evaluation Component.** The geriatric evaluation component of GEM consists of a comprehensive, multidimensional assessment followed by the development of an interdisciplinary plan of care. Provision of geriatric evaluation, including the disciplines involved in the process, must be reported with the procedure code S0250, whether the service is provided in an outpatient setting (e.g., Geriatric Primary Care clinic (Decision Support System (DSS) Identifier (ID) (350); GEM clinic (319); Geriatric Problem-focused clinic (formerly called "Geriatric Clinic") (318); Alzheimer's and Dementia clinic (320); Geriatric Research, Education and Clinical Center (GRECC) clinic or an inpatient setting (e.g., in one of the Community Living Center (CLC) Treating Specialties, such as 42-47, 64, 66-69, or 95-96, 1A, 1B, 1C, 1D, 1E).

(2) **The Management Component.** The management component of GEM consists of the implementation and follow-up of the treatment, rehabilitation, health promotion, and social service interventions specified in the plan of care by key personnel, such as: physician or other independent provider (e.g., physician assistant or nurse practitioner), nursing, social work, rehabilitation staff, and administrative staff.

h. **Geriatric Problem-focused Clinic.** Geriatric Problem-focused clinic is a general term (called “Geriatric Clinic” until 9-30-09) that may be used for any one of a number of specialty clinics (e.g., memory loss clinic, falls clinic, incontinence clinic, etc.) devoted to the assessment and management of a particular geriatric syndrome, such as falling, gait and balance disorders, failure to thrive, incontinence, memory loss, depression, or impaired cognition.

i. **Interdisciplinary.** “Interdisciplinary” is the term applied to a group or a process involving health professionals of several disciplines operating synergistically. This generally includes: geriatricians or suitably-prepared physicians, nurse practitioners, and physician assistants; nurses; social workers; pharmacists; mental health providers; and rehabilitation professionals; all of whom are experienced in working as a coordinated unit in the patient-centric assessment and management of complex, frail elderly individuals.

(1) **Interdisciplinary Geriatrics Team.** Interdisciplinary geriatrics team members have advanced training and experience in addressing the discipline-specific, health-related challenges encountered in frail, chronically-ill Veterans of advanced age; in communicating and collaborating effectively with health professionals from other health disciplines and community agencies; and in communicating effectively with the population served, including elderly Veterans and their caregivers.

(2) **Interdisciplinary Plan of Care.** An interdisciplinary plan of care is the cohesive integration of each individual disciplines’ input. This is effective because each interdisciplinary team member’s expertise gives rise to care plan elements addressing particular patient needs that cross traditional discipline-specific boundaries.

j. **Service Agreements.** Service agreements are written agreements between potentially consulting and consultant services, and consisting of the information needs of the consulted service, the expected results and timeframe of the consultation, and inclusionary and exclusionary criteria, if any.

4. REQUIRED GERIATRIC AMBULATORY CARE SERVICES

a. By statute (title 38 United States Code (U.S.C.) §1710B[a][1]), all enrolled Veterans likely to benefit from geriatric evaluation must be able to access that service. Geriatric evaluation may be provided in a range of inpatient and outpatient programs, so there is no single mandated program that all VA health care systems must have in place for the provision of that service. Each facility determines which program or programs it will offer that provides geriatric evaluation (e.g., Geriatric Primary Care, Inpatient and Outpatient GEM, CLC, HBPC, Alzheimer’s and Dementia Clinic, Geriatric Problem-focused Clinic, GRECC clinic, etc.) on the basis of the Veteran population served, the availability and preferences of suitably-trained staff, and the needs of the medical, associated health professionals, and trainees involved.

b. By statute (38 U.S.C. §1710B[a][5]), all enrolled Veterans who would likely benefit from HBPC must be able to access that service. The Office of Geriatrics and Extended Care is committed to implementing models for delivering this service even in areas relatively remote from VA medical centers, and working with health care systems to address such needs as they exist or arise.

5. GOALS

The goals of the geriatric ambulatory care programs include:

- a. Maintaining each patient in the least restrictive environment;
- b. Minimizing the progression of chronic disease, and assisting the Veteran, family, or other caregivers to cope with all elements of the disease;
- c. Reducing the need for, and providing acceptable alternatives to, hospitalization, nursing home care, and emergency department visits;
- d. Minimizing and optimizing medication regimens;
- e. Enhancing self-efficacy through education and respect for patient choices; and
- f. Ensuring a seamless progression from predominantly curative to more palliatively-focused chronic disease management or end of life care, when dictated by disease progression and patient preference; and in this way, to allowing the Veteran the option of dying at home.

6. RESPONSIBILITY OF THE FACILITY CHIEF OF STAFF (COS)

a. The facility COS is responsible for ensuring that all geriatric ambulatory care programs offered at a facility are adequately staffed and supplied, and are provided adequate clinical and administrative space.

7. RESPONSIBILITIES OF THE FACILITY CHIEF, PRIMARY CARE

The Chief, Primary Care is responsible for working with the Associate COS (ACOS) for Extended Care (EC), or the equivalent, to establish service agreements (see subpar. 3j) and specific inclusion and exclusion criteria for the geriatric ambulatory care programs offered at the facility.

8. RESPONSIBILITIES OF THE ACOS FOR EC

The ACOS for EC, or equivalent, is responsible for:

- a. Working with the Chief, Primary Care to establish provider agreements and specific inclusion and exclusion criteria for the geriatric ambulatory care programs offered at the facility.

b. Establishing policies and procedures for facility geriatric ambulatory care programs and ensuring program quality through a suitable blend of quality assurance approaches.

9. TARGET POPULATIONS

Although the term “Geriatric Ambulatory Care” implies a service for those of advanced age, enrolled Veterans of any age with dependency and impaired function due to multiple chronic diseases are eligible for, and may benefit from, the programs described in this Handbook. **NOTE:** *The inclusion and exclusion criteria that are specific to each program are in the specific program Handbooks.*

10. WORKLOAD REPORTING

Facility Geriatric staff must consult with the facility DSS Site Team to ensure correct Veterans Health Information and Technology Architecture (VistA) clinics and DSS IDs are set up for workload reporting. **NOTE:** *The National standard list of active DSS Identifiers for each fiscal year is posted on the DSS Web site at:*

http://vaww.dss.med.va.gov/programdocs/pd_oident.asp. The following DSS IDs are applicable to Geriatrics, but not necessarily exhaustive. **NOTE:** *If possible, consult the national standard list.*

- a. Primary care encounters are reported with DSS ID 323, regardless of the age or complexity of the patient.
- b. HBPC encounters are coded based on the discipline of the provider. The DSS IDs used will fall within the range 170-178 and 156-157.
- c. Geriatric Primary Care encounters are reported with DSS ID 350.
- d. Geriatric Problem-focused Clinic encounters are reported with DSS ID 318.
- e. GEM workload delivered in an outpatient program or clinic is reported with DSS ID 319.
- f. GRECC clinic workload delivered in an outpatient program or clinic is reported with DSS ID 352.
- g. When a geriatric evaluation (CGA and the development of the interdisciplinary plan of care) is provided on behalf of an outpatient during a clinical encounter in any other appropriate program (e.g., geriatric primary care, geriatric problem-focused clinic, etc.), other than HBPC, the procedure code S0250 is to be recorded on the encounter form completed by the independent licensed provider (ILP) (herein referring to the physician or, if no physician is participating in the process, the nurse practitioner or physician assistant).

(1) The encounter form must include the names of the providers of the two or more disciplines, in addition to the ILP, who participated in the interdisciplinary assessment and development of the plan of care.

(2) Because CGA involves an assessment completed by a number of providers, the assessment may not be completed at a single session. In all cases, full assessment is to be completed in a timely manner to ensure that a patient's status has not changed significantly between the initial and final assessments.

(a) The S0250 workload should not be reported until all individuals involved in developing the interdisciplinary plan of care have completed their contributions to the process. Yet sometimes the evaluation process extends over more than a single day and the independent licensed provider enters the S0250 after completing the ILP's part of the assessment. In that event, once all the assessments have been completed and the interdisciplinary plan of care has been developed, a note stating that the full plan of care has been completed, who contributed to it, and where it may be found, is to be made as an addendum to the ILP's original note.

(b) In the event more than one encounter form is generated in the course of the assessments (e.g., each provider completes one), only one of those encounter forms, the one completed by the ILP, is to include the S0250 code.

(3) Although the preferred method for developing an interdisciplinary plan of care is the interdisciplinary team meeting, this is not possible for all situations, particularly in the outpatient setting. Other acceptable approaches include:

(a) Informal exchanges, properly documented, resulting in an interdisciplinary plan of care; or

(b) Notes completed by representatives of different contributing disciplines, as "addenda" to a "parent note" that contains the plan of care (see VHA Handbook 1907.01).

(4) Geriatric evaluation conducted as part of an HBPC encounter or group of encounters must not be recorded with S0250, because distinctive characteristics of the HBPC Workload Data Package count this workload in a different manner. Specifically, every new admission to HBPC must be reflected in workload summaries as one episode of geriatric evaluation.

NOTE: Geriatric evaluation provided on behalf of an inpatient is beyond the scope of this Directive, but it should be noted that, in such an event, the procedure code S0250 must nevertheless be recorded through a mechanism of an inpatient encounter through a proxy clinic.

11. QUALITY ASSURANCE

The continuous performance improvement, quality assurance, and oversight mechanisms bearing on the ambulatory geriatric programs reflect and preserve the important role that these clinical services play in fulfilling the mandate to VHA to offer non-institutional alternatives to extended care in the least restrictive environment.

a. Since 2002, the Office of the Deputy Under Secretary for Health for Operations and Management (10N) has monitored the national Average Daily Census of various non-institutional alternatives to long-term care and tied meeting or exceeding increasing targets to VHA leadership performance plans. HBPC is one of the programs included in this census.

- b. Both GPC and HBPC are accountable for providers' performance on the Healthcare Effectiveness Data and Information Set (HEDIS) preventive services measures, although many patients in those programs are excluded from inclusion in the calculations of several measures due to advanced age or concurrent morbidity. Providers need to rely on their clinical judgment when deciding whether to subject an elderly patient to procedures or target laboratory values for which a suitable evidence base in the population receiving care is inadequate.
- c. GPC, as well as Primary Care clinics are tracked with performance indices reflecting quality of care of geriatric outpatients. **NOTE:** *Performance by VA facility, Veterans Integrated Service Network (VISN), or nationally may be accessed at <http://vaww.pdw.med.va.gov/>.*
- d. HBPC performance is tracked through a program of measures through the External Peer Review Program administered through the Office of Quality and Performance.
- e. All of the ambulatory geriatric care programs strive to comply with national targets for waiting times and advance scheduling.

RELATIONSHIPS AMONG AND BETWEEN PRIMARY CARE, GERIATRIC CONSULTATION, GERIATRIC PRIMARY CARE, AND GERIATRIC EVALUATION AND MANAGEMENT (GEM) CLINIC

