

GERIATRIC PATIENT-ALIGNED CARE TEAM (GeriPACT)

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook provides terminology, policy, procedures and quality assurance options for Geriatric Patient-Aligned Care Team (GeriPACT) programs in VA medical facilities.
- 2. SUMMARY OF MAJOR CHANGES:** This Handbook updates Geriatric Primary Care terminology, program goals, target population description, workload reporting, and quality assurance options for GeriPACTs.
- 3. RELATED ISSUES:** VHA Handbook 1101.10, Patient Aligned Care team (PACT).
- 4. RESPONSIBLE OFFICE:** The Chief Consultant for Geriatrics and Extended Care, in Patient Care Services (PCS) is responsible for the contents of this Handbook. Questions may be referred to 202-461-6750.
- 5. RESCISSION:** VHA Handbook 1140.07, dated September 25, 2008, is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of June 2020.

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GERIATRIC PATIENT-ALIGNED CARE TEAM (GeriPACT)

1. PURPOSE: This Veterans Health Administration (VHA) Handbook provides terminology, policy and procedures (including scope, goals, target population, and workload reporting), and quality assurance options for Geriatric Patient Aligned Care Team (GeriPACT) programs in VA medical facilities. **AUTHORITY:** 38 U.S.C. 7301(b).

2. BACKGROUND:

a. In early 2009, the Department of Veterans Affairs (VA) Universal Services Task Force Report, *Veterans Health Care: Leading the Way to Excellence*, recommended the formal adoption of a team-based model of care featuring three major principles: patient-centered care, coordination of care, and access to care. To apply these principles more completely within Primary Care, VHA adopted and customized the patient-centered medical home model of care. VHA branded its patient-centered care model “Patient Aligned Care Team” (PACT). The model was developed and launched in October 2009, as part of the Veterans Health Administration Transformational Initiatives. Guidance for PACT includes provision for “Special Population PACTs” that “provide comprehensive primary care and additional specialized care to a special population.”

b. In fiscal year (FY) 2012, over 52 percent of the 6.2 million Veterans receiving primary care in VA were age 65 years or older. Many in this age group, in addition to their multiple medical problems, have functional and cognitive impairments that are dramatically increasing in prevalence and severity with age. These characteristics among elderly Veterans markedly increase demands on staff and resource requirements for patient care. Veterans over age 85 years, the fastest growing subpopulation of VHA’s patients, represent the most cognitively and physically disabled category of the elderly Veteran population. Over half of the Veterans in this age group have a diagnosis of some form of dementia and require daily assistance with personal care needs. Yet most health care disciplines offer limited didactic and clinical training in care of the elderly pre-licensure, and few require demonstration of geriatric-related competencies as a condition for ongoing practice.

c. Prior to PACT’s emergence, “Geriatric Primary Care” programs were locally established at multiple points of VHA care delivery. This occurred in response to demand for longitudinal, interdisciplinary-team-based outpatient care for high-risk, high-utilization, and predominantly (but not exclusively) elderly Veterans. The demand arose because the multiple chronic diseases, dependencies, and reliance on both VHA and non-VHA support services typical of these patients were inadequately addressed in VHA primary care settings due to time and staff competency constraints. The transition of Geriatric Primary Care programs into GeriPACTs following the 2009 general PACT introduction was a logical and relatively straightforward step.

d. GeriPACT offers enhanced expertise for managing Veterans whose healthcare needs are particularly challenging due to multiple chronic diseases, coexisting cognitive and functional decline as well as psychosocial factors. GeriPACT integrates and coordinates traditional ambulatory and institution-based health care services with a

variety of community-based services. In this way, GeriPACT strives to optimize independence and quality of life for these particularly vulnerable Veterans in the face of their multiple interacting cognitive, functional, psychosocial, and medical challenges. GeriPACT synergizes and enhances the efforts and expertise of primary care providers and interdisciplinary team members who possess advanced training in assessing and addressing the functional dependencies, syndromes and illnesses of vulnerable and elderly Veterans, within the context of those impairments.

e. Close collaboration between PACT and GeriPACT within a health care system is necessary, requiring cooperation in scheduling, staffing, space assignment, referral criteria, and transfer protocols. This collaboration facilitates PACT patient flow by providing an alternative means for addressing the outpatient needs of a relatively small subset of particularly complex and time-consuming patients. Coordination with GeriPACT thereby enhances PACT's abilities to devote time and clinical expertise to non-geriatric PACT patients.

3. DEFINITIONS:

a. **Geriatric Syndrome.** Geriatric syndrome is the general term for any one of a set of variable clinical states of dysfunction characteristically but not exclusively seen with advancing age. The clinical dysfunctions include heightened vulnerability observed among individuals of advanced age, indicative of one or more underlying disease states combined with atypical presentation, functional impairment and likelihood of progression. Examples of geriatric syndromes include:

- (1) Failure to thrive;
- (2) Frailty;
- (3) Delirium;
- (4) Falls;
- (5) Disorders of gait and balance;
- (6) Incontinence of bowel or bladder;
- (7) Dementia and others causes of impaired cognition;
- (8) Depression;
- (9) Polypharmacy; and
- (10) Malnutrition.

b. **GeriPACT.** GeriPACT is a "Special Population PACT" for complex geriatric and other high-risk, vulnerable Veterans. GeriPACT provides the integrated, interdisciplinary assessment and longitudinal management of the health and care needs

of a spectrum of particularly vulnerable, predominantly elderly, at-risk Veterans, most of whom live with complex chronic disease, functional dependency, cognitive decline and psychosocial challenges (e.g., issues with at-risk caregivers, competency, coordination of VA- and non-VA-provided supports and services).

(1) At one end of this spectrum are high-functioning seniors seeking the services of a provider and care team whose professional interests are focused exclusively on care of the elderly. At the other end of the spectrum are the most frail, complex, and challenging Veterans, often but not always of advanced age, requiring a primary care provider with specialized clinical expertise plus familiarity with integrating a suitable mix of community services and other support mechanisms, including palliative care, necessary to provide integrated care to those whose lives are marked by coexisting functional, social, cognitive, and medical problems. The limited supply and uneven distribution of VHA personnel with advanced competencies in geriatrics dictates that most GeriPACT activity in VA needs to concentrate on Veterans closer to the latter end of the spectrum.

(2) GeriPACT is distinct from “geriatric consultation,” the latter being a one-time or at most limited duration assessment with recommendations for management, assistance in determining decision-making capacity for medical treatment or selection of living arrangement, or time-limited case management on behalf of a frail elderly patient. Geriatric consultation for outpatients may be provided by GeriPACT providers but is not itself GeriPACT.

c. GeriPACT Provider.

(1) A GeriPACT provider is a physician (MD or DO), physician assistant (PA), nurse practitioner (NP), or clinical pharmacist with a scope of practice, with training and certification, or who has had suitable extensive, gerontological, supervised clinical experience. This clinical experience must be in the management and co-management with primary care 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.

(2) Because many GeriPACT providers are assigned other VA responsibilities, their daily availability to their panel may be unavoidably limited. To minimize the impact of this on continuity of and access to care, GeriPACTs are encouraged to undertake one or both of the following strategies:

(a) Due to the higher prevalence of cognitive impairment and dependency on others for transportation among Veterans of advanced age, some GeriPACT patients and their caregivers may benefit from scheduling follow-up visits at the conclusion of an appointment, rather than routinely relying on recall scheduling. To ensure ability to accommodate GeriPACT patients able to utilize same day appointments for urgent care needs, GeriPACT clinic schedules should also include one or more open appointment slots per clinic session to accommodate such urgent care requests, thereby reducing the need for urgent or emergent care with a provider unknown to the patient. GeriPACT

providers should ensure Veteran patients (especially those with cognitive impairment) and caregivers are informed about any limitations to provider availability and are encouraged to time their regularly scheduled visits accordingly; and

(b) A NP or PA may be paired to operate as a team with a physician, to share responsibility for the GeriPACT panels assigned to each. This is an evidence-based arrangement that has a decades-long, successful history in geriatric practice. Each GeriPACT is encouraged to undertake this strategy; if it does, special measures, described in paragraph 8.b., are required when setting up the team in the Patient Care Management Module (PCMM), to ensure that workload and continuity in, and access to, providers are reflected accurately.

d. **GeriPACT Team.** The GeriPACT team is a collaborative partnership with an interdisciplinary team of suitably prepared health care professionals. It consists of the GeriPACT provider, a registered nurse, a social worker, a Clinical Pharmacist, a clinical associate (generally a licensed vocational nurse, licensed practical nurse, or health technician), and clerical staff. Following PACT terminology, this group is referred to as the “GeriPACT Teamlet;” other clinicians (e.g., mental health professional, dietician, occupational and physical therapist, audiologist, etc.) are also involved in clinical care as patient needs or local preferences dictate.

e. **Interdisciplinary.** “Interdisciplinary” is the term applied to a group or a process involving health professionals of several disciplines operating synergistically.

(1) In the context of GeriPACT, this includes geriatricians or suitably-trained physicians, nurse practitioners, physician assistants, nurses, social workers, clinical pharmacists, dietitians, mental health providers, rehabilitation professionals, and chaplains. These individuals are experienced in working as a coordinated unit in the patient-centric assessment and management of complex and vulnerable, mostly but not exclusively elderly individuals.

(2) Interdisciplinary team members have advanced training and experience:

(a) In identifying and contributing what is required of each team member, which in turn requires deliberate and regular devotion of time and effort to effective team function;

(b) In the discipline-specific, health-related challenges encountered in vulnerable, chronically ill, dependent Veterans, particularly but not exclusively those of advanced age;

(c) In communicating and collaborating effectively with health professionals from other health disciplines; and

(d) In communicating effectively with the population served, including elderly Veterans and their caregivers.

(3) An interdisciplinary plan of care is more than the sum of the input of individual disciplines because the familiarity of each interdisciplinary team member with the range of contributions and the scope of expertise of every other team member gives rise to care plan elements that cross traditional discipline-specific boundaries in response to particular patient needs.

4. SCOPE: GeriPACT is responsible for supporting co-located PACTs by providing primary care for Veterans, whose specific functional, medical and/or psychosocial characteristics might be best served by the specialized skill sets of GeriPACTs. GeriPACT's responsibility is initiated:

a. When a new patient meets specified inclusion criteria and is assigned to a GeriPACT panel as part of the health system's customary mechanism for assigning new patients to a team or primary care provider; or

b. When a PACT in collaboration with the Veteran/caregiver agrees to seek a transfer of primary care responsibility to GeriPACT for a Veteran meeting specified inclusion criteria (see Paragraph 7.b.).

5. RESPONSIBILITIES:

a. **Facility Chief of Staff.** The facility Chief of Staff is responsible for:

(1) Setting the number of clinic sessions devoted to GeriPACT; and

(2) Ensuring the clinic sessions devoted to GeriPACT are appropriately staffed and have suitable administrative support and clinical space. Because of the complexity of the patients served in GeriPACT, the pro-rated full-time panel size of a physician geriatric provider must not exceed 2/3 of the panel capacity set for the facility's physician PCPs. For non-physician geriatric providers, the pro-rated full-time panel size must not exceed 2/3 the panel capacity set for the facility's independent non-physician PCPs.

(a) As with all panel capacity determinations, these limits may need to be decreased in the absence of adequate support staff, limited access to a sufficient number of exam rooms, or complexity of the assigned patient population.

(b) Panel size for GeriPACT providers who are not full time devoted to delivering primary care in GeriPACT (e.g., those who also staff other geriatrics programs such as Community Living Center, geriatric consultation, home-based primary care, and palliative care) needs to be proportional to the time devoted to delivery of primary care. For example, a provider who is assigned to 6 half-days of GeriPACT clinic, and who spends 2 half-days per week (1/3 of her GeriPACT time) in the clinic addressing requests for consultation and 4 half-days (2/3 of her GeriPACT time) delivering primary care, the maximum panel size at a VA medical facility where PACT panel size is 1,200 will be calculated as follows:

$$\underline{1.} \text{ Maximum panel size} = (1200) \times (2/3) \times (6/10) \times (4/6) = 320.$$

2. Interdisciplinary GeriPACT teamlet members need to be physically present in the clinic during clinic hours.

3. During each GeriPACT clinic session, a minimum of one room, and preferably two rooms, are assigned per GeriPACT provider seeing Veterans during that session, to optimize provider and team efficiency.

b. **Chief, Primary Care Service.** The Chief, Primary Care Service, or equivalent official, is responsible for working with the GeriPACT Program medical director or equivalent role to explicitly define referral and inclusion criteria in accordance with guidelines in paragraph 7 (Target Population); and to facilitate the communication of these to PACT providers through service agreements, periodic in-service educational programs, or other effective means. The referral criteria may vary by site according to availability of GeriPACT and the resources available for managing the needs of particularly complex and dependent Veteran patients.

c. **GeriPACT Medical Director.** The GeriPACT medical director (or equivalent role with a different, locally selected title), is responsible for working with the Chief, Primary Care Service to establish referral criteria and transfer and co-management protocols, and is also responsible for:

(1) Ensuring complete, accurate, and timely GeriPACT workload reporting (see paragraph 8);

(2) Communicating mission and goals, outcomes, resource needs and recommended sources, noteworthy accomplishments, and emergent issues and options for addressing them, to facility leadership, staff, and relevant clinical services on a regular basis;

(3) Ensuring that the GeriPACT program fully meets the standards for PACT programs (see VHA Handbook 1101.01 Patient Aligned Care Team (PACT)).

(4) Ensuring that the quality assurance program for GeriPACT encompasses both required PACT metrics that are not in conflict with the best interest of the Veteran and all of the VHA quality indicators that target frail elderly (see paragraph 9).

d. **Chief, Pharmacy Service.** The Chief, Pharmacy Service will ensure that a clinical pharmacist with advanced training or certification in geriatrics is available and that the GeriPACT providers and teams have access to clinical pharmacy services to support medication and disease management needs of the GeriPACT patients.

6. GOALS: GeriPACT shares with PACT the fundamental standards of continuity, access and timeliness, comprehensiveness, coordination, and practice in the context of family and community. Specific goals of GeriPACT include:

a. Maintain each Veteran in the least restrictive environment;

b. Minimize the progression and maximize the control of chronic disease;

- c. Optimize medication regimens, minimizing polypharmacy to the greatest possible extent;
- d. Maximize each Veteran's functional ability and quality of life for the Veteran and caregiver(s) in the face of chronic disease and dependency;
- e. Enhance self-efficacy through education and respect for Veteran/caregiver choices;
- f. Ensure a seamless progression from predominantly curative to more palliative-focused chronic disease management when dictated by disease progression and Veteran preference; and
- g. Assess and address need for caregiver support as permitted.

7. TARGET POPULATION: GeriPACT focuses on a specified target population to take full advantage of the limited number of GeriPACT providers, and to maximize the benefits of these services to the health care system for most effectively serving the full Veteran population.

a. Acceptable inclusion criteria may include, but are not limited to, one or more of the following:

(1) A combination of multiple medical, functional, and/or psychosocial concerns, characteristically associated with advanced age, that is likely to benefit from assessment and management through an interdisciplinary team approach;

(2) One or more geriatric syndromes, examples provided in paragraph 3.a.

(3) Documentation of persistent suboptimal outcomes while managed in PACT (e.g., elevating requests for PACT visits, frequent ER visits, repeated hospitalizations, etc.) and a realistic potential for improvement if managed in GeriPACT;

(4) Elder abuse or neglect;

(5) Risk for long term care placement or concerns about ongoing independence in living arrangements; or

(6) Impending disability with potentially alterable health risks.

b. Proposed transfers of patients to a GeriPACT panel should always be the result of inter-professional dialogue or local facility service agreements. Such dialogue can be facilitated through the use of collaborative service agreements between PACT and GeriPACT, the terms of which have been developed jointly. Transfers are subject to approval by the GeriPACT Medical Director and justification for a refusal must be documented in the patients' medical record. Patients preferring to remain with their PCP and PACT who would still benefit from GeriPACT input, can be managed through available geriatric consultation and co-management.

c. Although one GeriPACT goal is to halt, or slow progression of, functional decline, even for clinical successes, the medical complexity of Veterans managed in GeriPACT requires the care team remain alert to signs indicative of decline, such that transfer of care to a program offering a higher level of support should be considered. When more frequent appointments, telehealth support, non-institutional services, and caregiver support options are unsuccessful at stemming a Veteran's decline the team needs to educate the Veteran/caregiver to explore the feasibility and acceptability of transfer to Home-Based Primary Care or Palliative Care; or alternatively or to consider (based on availability and suitability for addressing patient's needs) VA Community Living Center, State Veterans Home, Community Nursing Home, Medical Foster Home, or assisted living.

8. WORKLOAD REPORTING:

a. GeriPACT is identified for the purposes of clinic workload capture and cost by Decision Support System Identifier (Stop Code) 350, "GeriPACT" (previously known as "Geriatric Primary Care"). Each GeriPACT encounter must be recorded with Stop Code 350 and an Evaluation and Management (E&M) Current Procedural Terminology (CPT) code. For each GeriPACT episode that includes or consists of an interdisciplinary geriatric evaluation and the development of a plan of care by a GeriPACT provider and representatives of at least two other disciplines, the Healthcare Common Procedure Coding System (HCPCS) code, S0250, must also be included on the encounter form, in addition to the appropriate Evaluation and Management Code that records clinician productivity.

b. In the event (as encouraged in paragraph 3.c. above) a physician and an NP or PA are operating as a team to optimize continuity of and access to care for their panel of Veterans, the following steps are necessary to ensure that both of these outcomes (continuity and access to care) are accurately reflected in PCMM:

(1) The team must be established in PCMM with the physician identified as the "preceptor" and the NP or PA identified as the "associate provider;" and

(2) All Veterans of the physician's panel and the NP's or PA's panel must be assigned in PCMM to the "associate provider." When data are extracted from the PCMM record system for these panels, the assignment record of each Veteran will be associated with both the physician and the NP or PA.

(3) This process makes it possible for the Veteran to be seen by either the physician or the associate provider (NP or PA), and thus the performance metrics represent the activity of both providers. It does cause the panel size to be reported as a total for the team, rather than each individual's panel size being represented individually, and this must be considered when review and analysis of the clinic data and PACT reporting are conducted.

(4) It is important to note that these designations within PCMM are required by its software characteristics and are not reflective of reporting relationships that have not otherwise been established.

9. QUALITY ASSURANCE:

a. GeriPACT is subject to most of the same performance metrics as PACT. GeriPACT performance on certain population-based clinical performance metrics (e.g., hemoglobin A1c lipid, and blood pressure control, referral for exercise for obesity, pneumococcal immunization) is not reflected in host sites' and Veteran Integrated Service Network (VISNs') performance because Veterans over a certain age (usually age 70 or 75 years) are excluded from the summary calculations when the original validation studies for the measures included insufficient numbers of subjects above a specified age. Such exclusion should not be construed as clinical guidance. In the absence of an adequate evidence basis for undertaking a diagnostic procedure or initiating a course of care, the GeriPACT clinicians' clinical judgment should be the primary determinant for treatment decisions.

b. "Frail Elderly Indicators" are an expanding set of quality indicators supported in the literature as appropriate for outpatient care expressly for Veterans age 75 years and older. These indicators are tracked by the VHA Office of Analytics and Business Intelligence, Office of Performance Measurement. Indicator definitions, and VA medical facilities' and VISNs' performance in achieving the goals set for them, appear in the Office of Analytics and Business Intelligence Electronic Technical Manual" (<http://vaww.rs.rtp.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Performance+Reports/Measure+Management/MeasureCatalog&rs:Command=Render>). **NOTE:** *This is an internal VA Web site not available to the public.*

c. GeriPACT programs are encouraged to track the sources and justifications for referrals, consultations, and collaborations, in order to support an ongoing program of referral criteria refinement and care process improvement, and to build a record that demonstrates patterns and extent of support to the health care system in general and to PACT in particular.

10. REFERENCES:

- a. VHA Handbook 1140.04, Geriatric Evaluation and Management Procedures.
- b. VHA Directive 1731, Decision Support System (DSS) Outpatient Identifiers.
- c. VHA Handbook 1101.10, Patient Aligned Care Team (PACT).