GERIATRICS CONSULTATION

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive defines the scope, goals, target population, and workload reporting for Geriatrics Consultation programs in VA facilities.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Expanded background discussion to include updated demographic information and descriptions of geriatrics training requirements, importance of interdisciplinary teams, and the educational role of geriatrics clinicians.

b. Broadens the description of the responsibilities of VA leadership across levels.

c. Updated information on the settings for consultation and methods of workload reporting to reflect current practice.

3. RELATED ISSUES: VHA Handbook 1140.04, VHA Handbook 1140.07, VHA Handbook 1101.10, VHA Directive 1140.11, and VHA Directive 1232(1).

4. RESPONSIBILE OFFICE: The Chief Consultant for Geriatrics and Extended Care (10P4G), in the Office of Patient Care Services (PCS) is responsible for the contents of this directive. Questions may be addressed to 202-461-6750.

5. RESCISSIONS: VHA Handbook 1140.09, dated December 2, 2009 and VHA Directive 1140.10, dated April 26, 2010 are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Poonam Alaigh, M.D.
Acting Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on June 29, 2017.

CONTENTS

GERIATRICS CONSULTATION

1. PURPOSE 1
2. BACKGROUND 1
3. DEFINITION 2
4. POLICY 3
5. RESPONSIBILITIES 3
6. GOALS OF GERIATRICS CONSULTATION 5
7. TARGET POPULATION 6
8. SETTINGS 7
9. WORKLOAD REPORTING 8
10. REFERENCES 9

GERIATRICS CONSULTATION

1. PURPOSE

This Veterans Health Administration (VHA) directive describes the scope, goals, setting, target population, and workload reporting for Geriatrics Consultation programs in VA facilities. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b) and title 38 Code of Federal Regulations (CFR) 17.38.

2. BACKGROUND

a. To address the Department of Veterans Affairs (VA)'s core mission of population health while fulfilling its duty to be a responsible steward of taxpayer dollars, VA is committed to providing the highest quality of health care services to Veterans. Fulfillment of this commitment is reliant upon access to specialty and sub-specialty clinical expertise from clinicians of a range of health disciplines who have undergone advanced preparation and/or have acquired expertise in addressing health-related issues most prevalent in the Veteran population. Veterans age 65 years and over represented over 42 percent of the Veterans living in 2015. They also constituted over 46 percent of Veterans enrolled for VA health care, and more than 52 percent of the enrolled Veterans seeking VA health care in that year. Veterans over age 65 experience functional dependency and mental illness at a rate that is more consistent with non-Veterans aged 80 years and over, and they receive correspondingly high numbers of prescription medications (see paragraph 10.a.). Although virtually all Veterans over age 65 are eligible for Medicare and over 70 percent of them use Medicare to pay for some of their non-VA health care needs, they still account for over 50 percent of VA inpatient days of care, over 52 percent of outpatient visits, and over 60 percent of VA health care costs (VHA Medical Cost Accounting Office operational information). Yet the Institute of Medicine and the American Geriatrics Society have noted that didactic and clinical training in care of aging persons is limited or absent from the preclinical and clinical curricular requirements of medicine, nursing, and most other clinical disciplines. Access to subspecialty expertise in the management of Veterans of advanced age is therefore indispensable to VA health care.

b. Geriatric medicine is a recognized subspecialty of Internal Medicine, Family Medicine, and Psychiatry. Geriatricians (the term applied primarily to Internal and Family Medicine subspecialists) have undertaken a minimum of 1 year of Accreditation Council for Graduate Medical Education (ACGME)-accredited clinical training beyond residency in the diagnosis and management of diseases, conditions and concerns recognized as highly prevalent among those of advanced age. Geriatricians' practices customarily involve a blend of both primary care (i.e., longitudinal care) and a specialist role, in which they support, inform, and educate their peers on the management of the peers' aged and medically complex patients. This policy addresses the latter role. An Adult-Gerontology Nurse Practitioner (NP) is an advance practice registered nurse (APRN) with a population focus of adult-gerontology and specialized training and certification in the assessment and management of older patients. Educational preparation includes a Master's or Doctor of Nursing Practice degree and acute care

and/or primary care competencies based on their population of interest, and APRNs are licensed independent practitioners. Similarly, clinical pharmacy specialists complete a doctoral degree program followed by additional direct patient care experience (e.g., post-graduate residency training, board certifications, etc.) to provide comprehensive medication management services for older patients as an advanced practice provider. Psychologists also have programs and opportunities for gaining advanced training and certification in care for older persons. Corresponding advanced training opportunities in geriatrics exist for social workers; physical, recreational, and occupational therapists; audiologists and speech pathologists; and other members of the health care team.

c. The clinical practice of geriatrics entails working with and in the context of an interdisciplinary team that encompasses not only medical issues but psychosocial, dietary, environmental and cultural factors of health and well-being. Geriatrics offers particular expertise in management of multiple coexisting chronic conditions and geriatric syndromes in persons of advanced age, including multisystem conditions such as cognitive complaints, falls, incontinence, frailty, depression and behavioral changes. Geriatrics providers also bring expertise regarding long term care services and supports (and the payment mechanisms they entail), as well as considerations of advance care planning and end of life care.

d. Geriatrics consultation entails a strong peer-education commitment. Despite the growing prevalence of older adults, longer life expectancies, and greater care complexity of both the Veteran and non-Veteran United States population (e.g., the proportion of the US population age 65 and over is projected to increase from 15 percent in 2015 to over 22 percent by 2050), the number of physicians and other clinicians who have formal advanced training in geriatrics has been unchanged for over a decade and a growing proportion of training positions remains unfilled each year (see paragraph 10.b). Furthermore, many clinicians graduate from initial and often even advanced training experiences with limited didactic and clinical curricular time focusing on aged patients. Although one response to this challenge may be to limit geriatrics providers' time devoted to geriatric primary care, while focusing their time and energies on consultative work, controlled trials (e.g., paragraph 10.c.) document better outcomes for frail elderly patients managed by geriatricians and geriatrics teams compared to those managed by non-specialists, even when the latter receive individualized, comprehensive interdisciplinary plans of care. Consequently, an emerging expectation is for clinicians with advanced geriatrics expertise to enrich their primary care and consultative activities with a commitment to also educate their colleagues, thus enhancing the generalists' competencies in managing challenging geriatrics cases.

3. DEFINITION

Service Agreements. Service agreements are written agreements between potentially consulting and consultant services, which specify each service's expectations of the other party with respect to the consultation. These expectations may include, but are not limited to, inclusionary and exclusionary characteristics of patients about whom consultation is sought, the patient information that the consulting service should provide the consultant service within the consultation request, and

responsibility for post-consultation follow-up (including medication management) with the patient.

4. POLICY

It is VHA policy that geriatrics consultations are available and provided in multiple settings, including Patient Aligned Care Teams (PACT), urgent care and specialty care clinics, and inpatient units during acute care and extended care stays. Geriatrics consultations may be provided via face-to-face encounter, telehealth, or e-consult. Geriatrics consultation is generally inter-professional and addresses a range of interacting biopsychosocial concerns that often extends beyond the perspectives of a single health care discipline.

5. RESPONSIBILITIES

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Service Network (VISN) Director;

(2) Ensuring that each VISN Director has the resources required to support the fulfillment of the terms of this directive in all of the VA medical facilities within that VISN; and

(3) Confirming that each VISN has and utilizes on an ongoing basis a means for ensuring the terms of this directive are fulfilled in all the VA medical facilities of the VISN.

b. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for identifying a VISN-level Geriatrics and Extended Care (GEC) point of contact (POC), sufficiently resourced to fulfill his or her GEC-related responsibilities, including periodic travel to GEC leadership activities. This individual will have direct access to top VISN management and be appointed to serve on appropriate groups (e.g., Executive Leadership Council or the equivalent) as the VISN representative on GEC issues.

c. **VISN Geriatrics and Extended Care Point of Contact.** Each VISN GEC POC is responsible for coordinating the approach to comprehensive geriatrics consultative care for Veterans in the Network, to ensure that the requirements in this directive are fulfilled, thereby ensuring geriatrics consultation is equitably and consistently available within the VISN.

d. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that the means for providing geriatrics consultation is established and adequately resourced. ***NOTE:*** *Customarily the establishment and oversight of the necessary procedures is delegated to an Associate Chief of Staff for Geriatrics and Extended Care (ACOS/GEC) or an individual with another title who has been assigned equivalent responsibilities.* These procedures include but are not limited to:

(2) Identifying and then establishing with each potential requesting service (e.g., Surgery, Medicine, Physical Medicine, Neurology, Mental Health, Ambulatory Care, Primary Care, etc.) a Service Agreement or a less formalized understanding, which makes clear to both parties the:

(a) Availability of geriatrics consultation;

(b) Range of patient presentations and concerns appropriate and inappropriate for initiating a request for geriatrics consultation;

(c) Information that needs to be contained in a request for geriatrics consultation;

(d) Elements of the response, documented in the computerized patient record system (CPRS), that can be expected, including:

(3) A written assessment and recommendation for management; and

(4) The plan for post-consultation involvement between the patient and the geriatrician or interdisciplinary team consulted, unless the expectation for such involvement was part of the original terms of the request for consultation, or it has already been specified by the Service Agreement in place between the consulting service and the geriatrics consultation team.

(5) Identifying, and where necessary, securing access to geriatrics consultation services, for clinicians in care settings in which the needed geriatrics expertise is not present on-site, such as many Community-Based Outpatient Clinics (CBOCs) or VA Medical Centers lacking this resource. For such situations, options need to be explored in advance of the inevitable request for geriatrics consultation so that need that does arise will be addressed in a timely manner. These options include, but are not limited to:

(a) Referral of the patient to another VA medical facility where such geriatrics expertise may be available;

(b) Clinical video telehealth linkage with the facility that lacks the geriatrics expertise, with a site that has that expertise available and is staffed by one or more clinicians with the necessary clinical privileges to provide such service; or

(c) Contact with one or more consultants at a nearby Geriatric Research, Education and Clinical Center (GRECC). ***NOTE:*** *A listing of GRECCs and their contact information may be found at*

https://www.va.gov/GERIATRICS/Geriatric_Research_Education_and_Clinical_Centers.asp.

(6) Ensuring that those who respond to consultation requests are aware of, and adhere to policy regarding, the reporting requirements for Geriatric Evaluation, using the Health care Common Procedure Coding System (HCPCS) procedure code S0250 (see paragraph 8).

e. **VA Medical Facility Business Office.** The VA Medical Facility Business Office is responsible for working with geriatrics consultants to ensure that workload is appropriately and adequately reported and represented.

6. GOALS OF GERIATRICS CONSULTATION

This policy promotes the following outcomes:

a. Enhancing the appreciation of non-geriatrics teams and clinicians of the availability for, and means for obtaining, clinical guidance on the management of complex patients of advanced age.

b. Increasing access to specialty geriatrics expertise from a suitable range of disciplines and promoting the utilization of best practices in the care of frail, elderly, complex Veterans;

c. Improving efficacy and focus of the processes of care in order to optimize clinical outcomes on behalf of older Veterans;

d. Improving access to geriatrics consultations by utilizing available clinical video telehealth modalities for synchronous support at a distance from the point of care; and undertaking a synchronous virtual consultation (limited to review of the medical record) when indicated;

e. Providing the requesting team or clinician with a succinct assessment of the specified clinical situation and relevant related issues, and a practical, prioritized interdisciplinary set of recommendations for management;

f. Educating and empowering caregivers and the requesting team/clinician about the particular clinical issues and management to enhance not only the specific clinical care of the individual Veteran who is the focus of the consultation request, but also through the application of knowledge gained to benefit the larger population of older Veterans in the future; and

g. Seeking to instill key values (such as patient autonomy, advocacy, fidelity, beneficence, respect, etc.) and principles (such as enhancing function, cognition and quality of life; optimizing the overall regimen and plan of care; reducing, halting or reversing functional decline; avoiding dependency and institutional long-term care; and cultural sensitivity and respect), which are at the core of the practice of geriatrics, into the subsequent management of all older Veterans' care.

7. TARGET POPULATION

a. Requests for geriatrics consultation need to be limited to a specified target population in order to:

(1) Take full advantage of the limited number of clinicians with geriatrics expertise;

(2) Maximize the benefits of these services to the other clinicians and the health care system; and

(3) Best serve the targeted patient population.

b. Inclusion criteria may include, but are not limited to, one or more of the following:

(1) "Geriatric syndromes," such as delirium, impaired cognition with or without behavioral disturbance, urinary or fecal incontinence, gait or balance disorder, driving challenges, depression, or falls;

(2) Medical or mental health condition(s) whose management is (are) made particularly complex by advanced age, frailty, or one or more comorbidities or coincident conditions;

(3) Continuing clinical or functional decline in the face of ongoing management;

(4) Challenges selecting or effecting transitions among care settings;

(5) Recurrent hospitalizations and readmissions or frequent Emergency Department visits;

(6) Consideration for extended care placement/GEC services, such as Community Living Center (CLC), Home Based Primary Care (HBPC), Homemaker/Home Health Aide, Respite, or Assisted Living;

(7) Repeated evidence of safety issues (e.g., automobile accidents, falls, burns, unsafe living situation, etc.) or suspicion of elder abuse or neglect (***NOTE:*** *Urgent safety concerns must always be addressed immediately and not permitted to persist while a referral is processed)*; or

(8) Impending disability, anticipating need for initiating or increasing community supports or addressing potentially alterable health risks.

c. Exclusion criteria may include, but are not limited to patients:

(1) Who are being referred exclusively for renewal of a community-prescribed medication;

(2) Who are enrolled in hospice;

(3) Whose primary diagnosis is substance use disorder;

(4) Whose primary diagnosis is untreated mental illness; or

(5) Whose primary diagnosis is Traumatic brain injury.

8. SETTINGS

Requests for geriatrics consultation may be initiated in the following settings depending on local needs and resources:

a. **Acute Mental Health Unit.** Geriatrics consultation in an acute mental health inpatient setting is often requested to address common geriatric syndromes such as dementia and delirium and their differentiation from depression, and issues of polypharmacy.

b. **Community Living Center.** In the event the medical personnel in the CLC has not undertaken advanced training or certification in geriatrics, geriatrics consultation may be sought in response to change in function, cognitive status or behavior; or to ensure adequacy of post-discharge support and housing arrangement.

c. **Emergency Department.** Geriatrics consultation provided in the emergency department (ED) is typically requested to assess geriatric syndromes such as delirium, falls, incontinence and frailty. Follow-up with the patient's PACT or other primary care provider (e.g., GeriPACT) is particularly important to ensure management recommendations provided in ED have been communicated in a timely, accurate, and effective manner.

d. **Home-Based Primary Care.** Geriatrics consultation may be provided either through electronic consultation or through a face-to-face encounter, either in the home or in a VA setting, for patients whose assessment and care requires additional input or perspective.

e. **Inpatient Acute Care Hospital.** Typical reasons for inpatient consultation include fall prevention; delirium avoidance, assessment and management; pressure ulcers and other hospital-associated complications; and discharge planning, particularly to ensure coordination with outpatient providers, caregivers and community supports. Participation by one or more clinicians with geriatrics expertise during team rounds offers input on inpatient clinical management, the inpatient environment of care, and discharge planning. Inpatient geriatrics consultation by an interdisciplinary team has a strong evidence base in the literature for substantially improved outcomes.

f. **Outpatient Clinic.** Geriatrics consultation provided for PACT supports care provided to patients with particularly challenging clinical presentations. Such consultation may occur in outpatient settings either shared within or adjacent to PACT clinic areas or in dedicated "Geriatrics" (e.g., GeriPACT, Geriatrics Clinic) space.

g. **Telehealth.** Geriatrics consultation via a telehealth modality may specifically be requested for assistance assessing or managing a geriatric syndrome in the face of the local absence of suitable expertise or a patient's compromised ability to travel to the

consultant. With increasing sophistication and availability of clinical video telehealth modalities for synchronous support at a distance from the point of care, distant consultation is increasingly common, and may include direct or indirect participation in a specific case, didactic presentations on topics of interest, and mentoring. If employed, however, the consultant must be sensitive to inherent limitations of telemedicine in the care and assessment of frail elders, such as a patient's hearing difficulty, preference for a face to face encounter, or cognitive impairment; and the clinician's limited ability to perceive non-facial cues from caregivers or olfactory cues of self-neglect.

h. **E-Consults.** Geriatrics consultation may take the form of "e-consult," in which the patient is not seen in person by the consultant or consultant team, either in the patient's room or in a clinic setting, but the consultant's response is based solely on the information in the electronic record.

9. WORKLOAD REPORTING

The consultant who responds to the request for consultation must report the workload to get credit for the effort expended, the time involved, and the expertise shared. Responding to a geriatrics consultation is reported with Stop Code 318:

a. For an outpatient encounter (i.e., where the consultant interacts with the Veteran in an outpatient setting), a secondary code may be used to reflect the setting in which the encounter occurred, e.g., PACT (323), GeriPACT (350), Dementia Clinic (320), or GRECC Clinical Demonstration (352).

b. For an inpatient encounter (i.e., where the consultant interacts with the Veteran in the inpatient setting), the Business Office will create a "proxy clinic" and, when documenting the inpatient encounter, the clinician should select the "proxy clinic" as the location of care associated with the note. After the note is finished, an encounter form will automatically be generated and must be completed by the clinician to ensure appropriate workload is captured.

c. b. For an outpatient encounter provided not in-person but via Clinical Video Telehealth (CVT), the secondary code may be used to reflect the Veteran's location where the CVT assessment was performed, e.g., Veteran at a VA site (690). At the CVT provider site, another secondary stop code may be used to reflect either the CVT provider's location at a VA site with the same station number as the Veteran's VA location (692), or at a VA site with a different station number than the Veteran's VA location (693), or for CVT services provided into the Veteran's Home (179). In addition to the CVT secondary codes, CHAR4 codes can be set up to document the clinical setting that delivered the service: GeriPACT, Dementia Clinic, etc. Regardless of setting, if the encounter included the provision of Geriatric_Evaluation (see VHA Directive 1140.04, Geriatric Evaluation and Management Procedures) the HCPCS code S0250 must be entered in the secondary position.

10. REFERENCES

a. Selim AJ, Berlowitz, DR, Fincke G et al. Health status of veteran enrollees in the Veterans Health Administration. J Am Geriatr Soc 2004; 52:1271-127.

b. IOM (Institute of Medicine), 2008. Retooling for an aging America: Building the health care workforce. Washington, DC: The National Academies Press.

c. Cohen, H.J; Feussner, J.R.; Weinberger, M., et al. A controlled trial of inpatient and outpatient geriatric evaluation and management. New Engl. J. Med. 346(12), March 21, 2002.