

GERIATRIC EVALUATION

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides procedures for clinical and administrative staff for developing and delivering Geriatric Evaluation (GE) within VHA clinical programs.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

- a. Updated background demographics and history.
- b. Inclusion of procedures to reflect the introduction and growth of Patient-Aligned Care Teams (PACT), the programs mainly responsible for primary care in VHA.
- c. Substitution of guidance concerning “Geriatric Evaluation” for the earlier guidance on “Geriatric Evaluation and Management programs.”

3. RELATED ISSUES: VHA Directive 1140.11, VHA Handbook 1140.07, and VHA Directive 1140.09.

4. RESPONSIBLE 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. RESCISSION: VHA Handbook 1140.04, dated May 13, 2010, is rescinded.

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 This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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

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REPORTING WORKLOAD FOR GERIATRIC EVALUATION WITH HEALTH CARE
PROCEDURE CODING SYSTEM (HCPCS) CODE S0250 A-1

GERIATRIC EVALUATION

1. PURPOSE

This Veterans Health Administration (VHA) directive provides procedures to clinical and administrative staff on developing and delivering Geriatric Evaluation (GE) within VA medical facilities. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1720 and Title 38 Code of Federal Regulations (CFR) 17.38.

2. BACKGROUND

a. In 1999, Public Law 106-117, the Veterans Millennium Benefits and Healthcare Act, specified that access to geriatric evaluation was mandated for inclusion in the Veterans health care benefits package.

b. In 2016, over 42 percent of the nearly 22 million Veterans in 2016 were age 65 and over, and 5.5 percent (1.25 million) of Veterans are over age 85. Over nine million Veterans of all ages are enrolled with the Department of Veterans Affairs (VA), and 46 percent of these Veterans are age 65 and over.

c. In 2015, more than 52 percent of the Veterans who received care from VA were in this age group. Persons of advanced age are more likely than younger individuals to live with chronic disease and disability, and to evidence more advanced states of the progressive effects of diminished physiologic resiliency. As such, a significant proportion of the aging population requires health care services and assistance with activities of daily living (ADL) on a regular basis. As a group, Veterans experience more chronic disease and disability than age-matched, non-Veteran counterparts, requiring VA to plan for growing health demands by aging Veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.

d. Comprehensive geriatric evaluation was developed in Great Britain during the 1940s largely through the work of Dr. Marjory Warren, who advocated the establishment of special geriatric units in hospitals for the purpose of assessing and treating the chronically ill elderly before consigning them for the remainder of their lives to long-term care homes (see paragraph 10.b.). An interdisciplinary team that has the input of medicine, nursing, social work, and rehabilitation therapy, she noted, is needed to undertake the assessment and care planning for these patients.

e. Eugene J. Towbin, M.D. established the first VA Geriatric Evaluation and Management (GEM) unit at Little Rock VA Medical Center in 1974 (see paragraph 10.c). In the inpatient hospital setting, early single-site studies found dramatic benefits in terms of improved survival and functional status with programs involving comprehensive geriatric assessment and management (see paragraphs 10.d and 10.e). Interest in geriatric evaluation grew largely from findings on the effectiveness of an inpatient GE program tested in a randomized controlled trial at the VA Sepulveda Greater Los Angeles VA Healthcare System Geriatric Research and Education Clinical Center (GRECC) (see paragraph 10.f). In a subsequent, multisite, VA trial that enrolled frail, hospitalized Veterans age 65 and older, participants were randomized to inpatient geriatric units or usual inpatient care, and then upon discharge were randomized into either: (a) what

might be considered low-intensity, outpatient geriatric clinics; or (b) usual outpatient care. There were significant reductions in functional decline with inpatient geriatric evaluation and management and improvements in mental health with outpatient geriatric care, in both cases with no increase in costs (see paragraph 10.g.).

3. DEFINITIONS

a. **Geriatric Evaluation.** Geriatric Evaluation (GE) consists of a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. GE is a specialized procedure undertaken by an interdisciplinary team of health care professionals, for a targeted group of predominantly older patients and others with medical and psychosocial complexity, who will most likely benefit from the service. Provision of geriatric evaluation is reported with the procedure code S0250. **NOTE:** For details on workload reporting for geriatric evaluation using the S0250 code, see Appendix A.

b. **Geriatric Provider.** A geriatric provider is a physician (MD or DO), physician assistant (PA), nurse practitioner (NP), or clinical pharmacist with a scope of practice, who has been trained and certified, 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.

c. **Interdisciplinary.** Interdisciplinary is the term applied to a group, or a process, that involves health professionals of several disciplines operating synergistically. In the context of GE, this generally includes geriatricians or suitably-prepared physicians, nurse practitioners and physician assistants, nurses, and social workers; and (according to the patient's issues and needs) pharmacists, dentists, dieticians, mental health providers, rehabilitation professionals, and health educators, all of whom are experienced in working as a coordinated unit in the patient-centric assessment and management of complex, frail elderly individuals. Members of an interdisciplinary team have advanced training and experience in:

(1) Assessing and addressing the discipline-specific, health-related challenges encountered in frail, chronically-ill Veterans of advanced age.

(2) Communicating and collaborating effectively with health professionals from other health disciplines.

(3) Communicating effectively with the population served, including elderly Veterans and their families and caregivers.

d. **Interdisciplinary Plan of Care.** An interdisciplinary plan of care is one integrated plan of care where the entire team works together to establish collaborative goals. It is more than the sum of individual disciplines' input because each interdisciplinary team member's familiarity 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 issues and needs.

4. POLICY

It is VHA policy that geriatric evaluations are provided in VA facilities to identify, assess, and develop a plan of care for addressing, in an interdisciplinary manner, the biopsychosocial status of severely disabled, frail, and/or older persons at risk for further decline and institutional placement, with the intention of optimizing their health, function, and ability to live with the greatest degree of independence suitable for their situations.

5. PROVISION OF GERIATRIC EVALUATION

GE is indicated for older Veterans who have experienced significant functional decline, or development of other geriatric syndromes (e.g., depression, dementia, delirium, urinary incontinence, gait and balance impairment, falls, etc.). GE must be available and provided in both outpatient and inpatient settings.

a. **Outpatient Geriatric Evaluation.** Outpatient GE offers comprehensive evaluation for older, community-dwelling people likely to benefit from the services offered in an outpatient setting.

(1) Outpatient GE is generally offered in one or more of the following programs:

(a) Geriatric Patient Aligned Care Team (GeriPACT) (Stop Code 350).

(b) GRECC Clinic (Stop Code 352).

(c) Home-Based Primary Care (HBPC) (Stop Codes 156, 157, 171-179).

(d) Geriatric Problem-Focused Consultation Clinic (Stop Code 318).

(2) Outpatient GE focuses on:

(a) Identifying the need for coordinated, interdisciplinary provision of medical, nursing, psychosocial, and preventive health services.

(b) Health education of patients, families, and caregivers.

(c) Referral for specialty, rehabilitation and other levels of care.

(3) Follow-up care and care management, directed by the findings of the Outpatient GE, is best provided by the team that undertook the GE but, with support of that team, can also be provided by:

(a) GeriPACT.

(b) HBPC.

(c) Patient-Aligned Care Teams (PACT), with or without co-management by GeriPACT.

b. **Inpatient Geriatric Evaluation.** Inpatient GE is generally for patients who are already in, or who are at significant risk for needing to be admitted to, an extended care setting. Inpatient GE may be necessary to assist in timely discharge, or may be the reason for the admission.

(1) Inpatient GE may be provided in either:

(a) Community Living Center (CLC), (Treating Specialty 81); or

(b) Acute Care setting, if the patient is not too ill to participate.

(2) Follow-up care and care management, directed by the findings of the Inpatient GE is provided either:

(a) Prior to discharge from the inpatient (CLC or acute care) setting;

(b) Following discharge, in GeriPACT or HBPC;

(c) Following discharge, in PACT, with or without co-management by GeriPACT; or

(d) Initial follow up in GeriPACT, followed by either Dementia Clinic or HBPC.

6. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for ensuring compliance with this directive.

b. **Deputy Under Secretary of Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management (10N), or designee, is responsible for:

(1) Communicating the contents of this directive to each of the VISN Directors;

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

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for:

(1) Appointing a VISN-level Geriatrics and Extended Care (GEC) point of contact (POC) and sufficiently resourcing this individual to fulfill GEC-related responsibilities, including periodic travel to GEC leadership activities.

(2) Ensuring compliance with this directive at every facility in the VISN.

d. **Veterans Integrated Service Network Geriatric and Extended Care Point of Contact.** Each VISN GEC POC is responsible for:

- (1) Ensuring GE is consistently available within the VISN's facilities.
- (2) Capturing and accurately reflecting the provision of GE in workload reports.
- (3) Serving as the VISN subject matter expert on GEC issues in the appropriate groups (e.g. Executive Leadership Council or the equivalent).
- (4) Participating in periodic GEC leadership activities.
- (5) Working with the VA medical facility Chiefs of Staff to identify options for fulfilling GE requests when the necessary expertise is not present on-site.

e. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring that the means for providing timely GE has been established and is adequately resourced at each VA medical facility.

f. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff is responsible for:

(1) Ensuring that GE is available in a timely manner when it is indicated. This includes establishing, scheduling, and providing clinical space as necessary.

(2) In the event the necessary expertise is not present on-site, as may be the case with Community-Based Outpatient Clinics (CBOCs) or some VA medical facilities, working with the VISN POC to identify in advance of the inevitable request for geriatrics evaluation one or more options for fulfilling the commitment to make available GE when it is indicated, so the 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 the service will be available.

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

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

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

g. **VA Medical Facility Business Office.** The VA medical facility Business Office is responsible for working with geriatric providers to ensure that GE workload is appropriately and adequately reported and represented using the Healthcare Common Procedure Coding System (HCPCS) procedure code S0250.

h. **Geriatric Evaluation Director.** The GE Director must be a geriatrician; a non-geriatrician physician with advanced clinical training in the management of complex elderly

patients; a nurse practitioner or physician assistant with advanced training in geriatrics; or another suitably-trained health professional who can fulfill the following responsibilities:

(1) Providing overall administrative responsibility for the GE, including performance improvement.

(2) Reviewing each GE staff member's performance and effectiveness to ensure a high standard of service.

(3) Planning and recommending training for GE staff.

(4) Coordinating GE-based education of other VA staff and trainees in geriatric medicine and gerontology principles.

(5) Keeping facility executive leadership and all other relevant staff informed about GE activities.

(6) Coordinating efforts to promote the activities of the GE throughout the facility and the community.

i. **Geriatric Evaluation Provider.** The GE Provider, or designee, is responsible for:

(1) Performing or supervising the medical evaluation and care of patients in the program.

(2) Providing patient and family education.

j. **Geriatric Evaluation Nurse.** The GEC Evaluation Nurse is responsible for:

(1) Completing the nursing assessment to identify patient problems based on the health and functional status data collected.

(2) Contributing to, implementing, and coordinating the plan of care.

(3) Educating nurses and other staff on GE principles including the prevention of functional decline and the support of restorative goals of care; and on relevant nursing procedures, including implementation of evidence-based protocols for enhancing patient independence.

(4) Facilitating referral to GE for those patients meeting admission criteria.

(5) Providing patient and family education.

(6) Facilitating interdisciplinary team meetings.

(7) Encouraging the participation of patients and significant others in the ongoing interdisciplinary team processes of assessment, development, revision of the plan of care and goal-setting.

(8) In an inpatient GE, assisting patients, family, and significant others in planning for the discharge of the patient to the most appropriate setting.

k. **Geriatric Evaluation Social Worker.** The GE social worker is responsible for:

(1) Providing a comprehensive psychosocial assessment and facilitating communication contact with patients' families or significant others.

(2) Arranging family meetings with appropriate team members to facilitate effective communication of the team plan to the patient and the family.

(3) Serving as a consultant to GE and other staff concerning the impact of social and emotional problems on older patient functioning.

(4) Developing the psychosocial treatment component of the overall treatment plan, including individual, family, and group interventions.

(5) Providing patient and family education.

(6) Facilitating, networking and linkage with VA services and community agencies as needed for supporting the Veteran's capacity to live in an optimal, patient-centered level of independence.

7. PATIENT SELECTION

The goal of patient selection criteria is to target GE service for those older people most likely to benefit from it. Factors that seem to play a role in the success of geriatric assessment include appropriate selection of participants to avoid older people who are "too sick" to benefit, and patients who are "too well" to justify the higher cost of additional hospital days (for inpatients) or assessments by multiple clinicians (for outpatients).

a. **Inclusion Criteria.** Patients who might best benefit from GE are most likely to be age 65 years and older and have either:

(1) Multiple medical, functional, or psychosocial problems, and could benefit from an interdisciplinary team approach.

(2) One or more "geriatric syndrome(s)," for example: dementia, delirium, functional decline, urinary incontinence, polypharmacy, elder abuse, unsteady gait or falls, malnutrition, or depression.

b. **Exclusion Criteria.** Patients who might best be excluded from GE are those who:

(1) Are acutely ill or need an intensive care unit.

(2) Need total care (e.g., severe irreversible dementia for which potentially reversible causes have been ruled out, severe cerebral vascular accident).

(3) Have a well-documented terminal illness with a life expectancy of less than six months or are actively dying. It is recommended that these patients be referred to the Palliative Care Consultation team or Hospice.

(4) Have an active substance abuse disorder. It is recommended that these patients be referred to Substance Abuse Treatment Program, or other suitable Mental Health program.

(5) Have an inadequate social support network for allowing for eventual return home.

(6) Lack suitable rehabilitation potential to allow for permanent discharge to any setting other than a community living center or nursing home.

(7) In the absence of depression or cognitive impairment, demonstrate a lack of motivation or have a documented refusal to participate in an interdisciplinary evaluation process.

8. PROGRAM EVALUATION AND PERFORMANCE IMPROVEMENT

a. Program evaluation and performance improvement activities are vital components of GE program function; thus, adequate staff time must be allocated to perform these activities. Program evaluation and performance improvement activities depend on clear delineation of measurable program objectives, ongoing procedures for monitoring specific care processes and outcomes, and regular analysis of findings.

(1) Performance improvement activities seek to reduce variation and optimize processes. Specific to GE, measurable program objectives may include such parameters as:

(a) Improved diagnostic accuracy.

(b) Reduced placement in nursing homes.

(c) Reduced frequency of episodes of emergency room utilization.

(d) Reduced hospitalizations.

(e) Improvement in physical or psychosocial functioning, except for those patients with a diagnosis indicative of progressive decline.

(f) Improvement in medication utilization.

(g) Establishment of coordinated interdisciplinary care plans.

(h) Facilitation of geriatric education and research.

(i) Interdisciplinary involvement in regularly scheduled team meetings.

(j) Establishment of patient-centered goals of care.

(k) Patient and family engagement and experience.

(l) Formulation of end-of-life care plans.

(m) Increased coordination with community programs and services.

(2) Monitoring program objectives involves the regular collection and analysis of data regarding:

(a) Diagnoses.

(b) Functional status changes.

(c) Use of institutional and non-institutional extended care and community agency services.

(d) Medication usage.

(e) Completion of goals of care conversations, advance directive discussions, and advance directives.

(f) Reduced number of alterable health risks.

(g) Patient and caregiver experience surveys.

(h) For in-patient GE only: length of stay and/or readmission rate.

(i) For education only: the number, disciplines, and origins of trainees, number of hours, changes in attitudes, behaviors, and outcomes.

(j) For research only: proposals submitted, proposals funded, funding total, publications accepted, abstracts accepted, and scientific presentations delivered.

b. Performance improvement activities for the GE Program must be coordinated with the Quality Management office at the facility, and reviewed by the same medical center leadership board that is responsible for oversight of all performance improvement activities at the facility.

c. Program evaluation and research studies conducted in the GE must be coordinated with the facility research office and research review committees.

9. EDUCATION MISSION

Training must be considered a continuous, ongoing activity. Program personnel must be alerted to improvements in geriatric assessment and treatment techniques that may be applicable to their own programs, disciplines, and practices. Training Resources include:

a. **Local Resources.** Ongoing training needs to involve utilization of local resources whenever possible. Use of technology, such as videoconferencing and

telecommunication, may help GE personnel obtain initial training, as well as, providing opportunities for ongoing professional enrichment through exchange of ideas locally, regionally and nationally.

b. **Other VA Medical Facility.** Inter-facility educational details must be employed to observe the functions of established GE Programs. **NOTE:** *It is recommended that experienced VA personnel be invited to visit a facility contemplating a new GE to support program planning and staff training.*

c. **Geriatric Research and Education Clinical Centers.** The GE model was originally developed and evaluated by two Geriatric Research and Education Clinical Centers (GRECCs) in the 1970's and has continued to serve as a dominant setting for geriatric care, education, training, and research at most GRECC sites. GRECC staffs serve as an excellent resource to:

1. VA medical facilities establishing new GE programs.
2. Those seeking outside evaluation of their existing GE programs.
3. Those considering changes in their current GEs.

d. **Non-VA Resources.** Where available, geriatric personnel should be encouraged and resourced to collaborate with, and take advantage of excellent training resources provided by: Geriatric Workforce Enhancement Programs, state and national American Geriatrics Society educational events, state and national American Medical Director Association meetings, and university centers on aging. The expertise and experience of VA personnel may in turn enhance the functioning of these associated programs and societies.

10. REFERENCES

- a. Public Law 106-117, the Veterans Millennium Benefits and Healthcare Act.
- b. 38 U.S.C. 1720.
- c. 38 CFR 17.38.
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- f. Cohen HJ, Feussner JR, Weinberger M, et al. A controlled trial of inpatient and outpatient geriatric assessment and management. N Engl J Med 2002; 346:905-12.
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i. Warren MW. Care of the chronic aged sick. *Lancet* 1946; i:841–3.

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**REPORTING WORKLOAD FOR GERIATRIC EVALUATION WITH HEALTH CARE
PROCEDURE CODING SYSTEM (HCPCS) CODE S0250**

Geriatric evaluation (GE) is a service that Public Law 106-117 specified for inclusion in the Veterans benefit package. For the purposes of program planning, standardization of services, and reporting to stakeholders, a mechanism for reporting this workload, whether delivered in an inpatient or outpatient setting, or in the home, has been developed and is described in the following.

1. GE is recorded with a Health Care Procedure Coding System (HCPCS) code, S0250, which is defined as “Comprehensive geriatric assessment and treatment planning for a patient with multiple chronic diseases characteristically encountered in persons of advanced age, made individually complex by one or more functional and psychological factors, performed by an assessment team.”

2. To track GE workload in the Department of Veterans Affairs (VA), the assessment team must be comprised of no fewer than three clinicians:

a. One of these clinicians must be an independent licensed provider (usually a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner, or Physician Assistant) who has advanced training, certification, or prior supervised clinical experience in managing the health needs of geriatric and other chronically disabled patients whose cases are made additionally complex by psychosocial or environmental factors.

b. The other disciplines most commonly involved are nursing, social work, and pharmacy. Other disciplines that may be involved include, but are not limited to, psychology, rehabilitation therapies, and dietetics.

3. Geriatric evaluation may be delivered in either inpatient or outpatient settings. The specific workload reporting procedure varies depending on the following settings:

a. **Outpatient Settings.**

(1) Outpatient settings that may include GE include: Geriatric Patient Aligned Care Team (PACT) (indicated with a clinic stop code with 350 in the primary position), Geriatric Research and Education Clinical Center (GRECC) clinic (352), Geriatric Problem-Focused Clinic or Geriatric Consultation or (318), Primary Care Clinic (323), Home-Based Primary Care Clinics (156, 157, 171-177) and others. It must be stressed that while geriatric evaluation may be provided in these settings, not all episodes of care in these settings will include GE, and only an episode of care that does so is to be documented as such.

(2) To record an episode of GE for an outpatient, the record of the encounter entered by the licensed independent provider must include the Healthcare Common Procedure Coding System (HCPCS) code S0250 and specify the other two clinicians of different disciplines participating in the process.

(a) The S0250 workload ideally should not be reported until all individuals involved in developing the interdisciplinary plan of care have completed their contributions to the process.

1. When the evaluation process extends beyond a single appointment, the time span between the first assessment and finalization of the plan of care needs to be as brief as possible (generally a week or less), to ensure that the status of the patient has not changed substantially.

2. When the evaluation process extends to longer than a single day, but the independent licensed provider has entered the S0250 after completing their part of the assessment, a note describing the full plan of care needs to be made as an addendum to the licensed independent provider's original note, once all the assessments have been completed and the interdisciplinary plan of care has been developed.

(b) When more than one encounter form is generated throughout the course of the assessment (e.g., each provider completes one), only the encounter form completed by the independent provider is to include the S0250 code.

(c) Individual disciplines' assessments and recommendations may be recorded in the health record in several ways, including:

1. Independent progress notes detailing each assessment, with the final plan specifying the dates, authors, and disciplines of each relevant assessment.

2. A single note summarizing the different assessments and the resulting interdisciplinary plan of care, and specifying the identities and disciplines of the contributors and the dates of the individual assessments.

3. 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).

b. **Inpatient Settings.** Inpatient GE is most commonly provided within CLC and usually is coded with Treating Specialty (TRT) 81, CLC GE Nursing Home Care. If GE is part of the service provided to a Veteran staying in the CLC but not in a dedicated GE TRT, the TRT will be one of those described for CLC in current VHA policy. Inpatient GE also may be provided within acute care units, in which case the TRT is 31 (GE Acute Medicine). It must be stressed that while GE may be provided in either of these settings, not all episodes of care in these settings will include GE, and only an episode of care that does so is to be documented as such.

(1) To record an episode of GE for an inpatient, an inpatient encounter must be generated to include the S0250 HCPCS code and the names of at least two individuals from different disciplines, in addition to the licensed independent provider involved in developing the interdisciplinary plan of care.

(a) The service most likely to record GE workload (e.g., Extended Care or Geriatric Medicine) needs to initiate a collaboration with local Information Technology personnel

(e.g., the Clinical Applications Coordinator, Medical Cost Accounting (MCA) Site Manager or MCA Clinical Coordinator, Health Information Management representative, etc.) to customize users' CPRS templates, clinics, procedures, and Evaluation and Management (E&M) codes options (including creation of a "proxy clinic," i.e., a "virtual" entity that will accept procedure codes without generating actual outpatient clinical workload).

(b) The S0250 workload is not to be reported until all individuals involved in developing the interdisciplinary plan of care have completed their contributions to the process. The time span between the first assessment and finalization of the plan of care needs to be within the particular ranges specified by local policy or accreditation requirements, whichever is more stringent.

(2) Individual disciplines' assessments and recommendations may be recorded in the medical record in several ways as detailed above in Appendix A, subparagraphs 3a(1)(c)1., 3a(1)(c)2., and 3a(1)(c)3.

c. **Homecare.** GE provided in Home-Based Primary Care (HBPC) must not be reported with the S0250 code. Every HBPC admission counts as a single episode of GE and adding the S0250 code to an HBPC encounter diminishes the accuracy of local, regional, and national GE workload data.