

GERIATRIC PATIENT ALIGNED CARE TEAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive sets forth policy and quality assurance for Geriatric Patient Aligned Care Team (GeriPACT) programs serving aging and Veterans with complex care needs in Department of Veterans Affairs (VA) medical facilities.

2. SUMMARY OF MAJOR CHANGES: This directive:

a. Updates Geriatric Primary Care terminology and removes language related to GeriPACT provider requirements and program goals.

b. Relocates information regarding Target Population, Workload Reporting and Quality Assurance to Appendices A, B and C, respectively.

c. Adds responsibilities for VHA, Veterans Integrated Service Network (VISN) and VA medical facility leaders (see paragraph 5).

3. RELATED ISSUES: VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT), dated February 5, 2014. VHA Directive 1406 Patient Centered Management Module (PCMM) For Primary Care, dated June 20, 2017.

4. RESPONSIBLE OFFICE: The Office of Executive Director for Geriatrics and Extended Care (12GEC) is responsible for the contents of this directive. Questions may be referred to 202-461-6750.

5. RESCISSION: VHA Handbook 1140.07, Geriatric Patient Aligned Care Team (GeriPACT), dated June 15, 2015, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of March 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY THE DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA
Assistant Under Secretary for Health
for Patient Care Services

March 23, 2021

VHA DIRECTIVE 1140.07

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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GERIATRIC PATIENT ALIGNED CARE TEAM

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy and quality assurance for Geriatric Patient Aligned Care Team (GeriPACT) programs in Department of Veterans Affairs (VA) medical facilities. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 7301(b).

2. BACKGROUND

a. Traditional Patient Aligned Care Teams (PACTs) care for Veterans with acute and chronic illnesses but GeriPACTs care for those Veterans with more complex care needs and intensive case management requirements. GeriPACT is a 'Special Population PACT' whose clinicians maintain a specialized skillset that allows for the care of complex, high-risk, vulnerable Veterans. Although many Veterans cared for by GeriPACTs are of advanced age, age is not a qualifying or identifying characteristic of the frail and vulnerable population.

b. GeriPACT provides integrated, interdisciplinary assessment and longitudinal management of the health and care needs across the lifespan for a spectrum of particularly vulnerable, at-risk Veterans. Most of these Veterans 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).

c. GeriPACT integrates and coordinates traditional ambulatory care with a variety of community-based services. In this way, GeriPACT programs strive 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 programs synergize and enhance 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. These programs offer enhanced expertise for managing Veterans whose health care needs are particularly challenging due to multiple chronic diseases, coexisting cognitive and functional decline and other psychosocial factors.

d. GeriPACT is designed to serve the most frail, those with complex needs and Veterans who may not always be of advanced age but require a primary care provider with both specialized clinical expertise and familiarity with integrating a suitable mix of community services and other support mechanisms, including palliative care, that are necessary to provide integrated care to those whose lives are marked by coexisting functional, social, cognitive and medical problems (see Appendix A for Qualifying Criteria). Because of this specialized knowledge, GeriPACT is well-suited to partner with traditional Primary Care PACTs to help identify these Veterans and accept many in referral for transfer and further management. (See PACT High risk Roadmap, available at:

<https://vaww.infoshare.va.gov/sites/primarycare/mh/pcmhinfo/imptools/General%20Impl>

[ementation%20Documents/PACT%20Implementation%20Roadmap-2012.pdf](#). **NOTE:** *This is an internal VA website that is not available to the public.*)

e. Close collaboration between GeriPACT and traditional PACT programs within the 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 needs of a subset of Veterans who require complex care and intensive case management. Based on local service-line structure, GeriPACT programs may be aligned with the Primary Care or the Geriatric Extended Care (GEC) service lines.

3. DEFINITIONS

a. **GeriPACT.** For the purpose of this directive, GeriPACT is synonymous with Geriatric Special Population PACT and refers to longitudinal primary care for 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. The care is provided and managed by a VA interdisciplinary team with provider (Physician, Nurse Practitioner or Physician's Assistant) oversight for this population in need of intensive case management. Many of the Veterans who make up this population subset are significantly impacted by social determinants of health, including but not limited to; adequate financial resources to meet basic needs, safe and stable housing and access to healthcare and other services.

b. **GeriPACT Team.** The GeriPACT team is a collaborative partnership that consists of an interdisciplinary team of Geriatric health care clinicians. Given the intensive case management needs of the Veteran population the GeriPACT Core team must include a Provider (Physician, Nurse Practitioner or Physician's Assistant), Registered Nurse, Social Worker, Clinical Pharmacy Specialist mental health professional, a clinical associate, a Licensed Vocational Nurse, Licensed Practical Nurse or health technician) and clerical staff. Other health care clinicians whose services are frequently needed for comprehensive care of complex older adults (e.g., dietician, occupational and physical therapist, audiologist) are also involved in clinical care as patient needs dictate. Geriatric clinicians possess and maintain appropriate specialty (Geriatric) certification as deemed appropriate by professional accrediting bodies (such as American Board for Family Medicine (ABFM), American Board of Internal Medicine (ABIM) or the American Nurses Credentialing Center (ANCC), this list is not all-inclusive).

c. **Panel Management.** Panel management is the administrative process of using clinical software (Primary Care Management Module (PCMM) or Cerner Millennium, when available) to assign and un-assign patients to a GeriPACT and to calculate, adjust and monitor panel size (see VHA Directive 1406 Patient Centered Management Module for Primary Care, dated June 20, 2017). **NOTE:** *Panel management is often confused with population management. Panel management only refers to management of assigning patients to a panel and managing the panel size.*

4. POLICY

It is VHA policy that GeriPACT supports co-located PACT programs by providing primary care for Veterans whose specific functional, medical or psychosocial characteristics are best served by the specialized skill sets of GeriPACT providers.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for supporting GEC with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Assisting VISN Directors in resolving implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Geriatrics & Extended Care.** The Executive Director, GEC is responsible for providing oversight of VISN and VA medical facility compliance with this directive and ensuring corrective action is taken if non-compliance is identified.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for ensuring that all VA medical facilities within the VISN comply with this directive and informing GEC program office when barriers to compliance are identified.

f. **VA Medical Facility Director or VA Medical Facility Chief of Staff or VA Medical Facility Associate Director of Patient Care Services.** The VA medical facility Director, the VA medical facility Chief of Staff or the VA medical facility ADPCS, depending on the VA medical facility, is responsible for:

(1) Ensuring overall VA medical facility compliance and quality of care oversight with this directive and taking appropriate corrective action if non-compliance is identified.

(2) Reviewing GeriPACT workload reporting from the VA medical facility Primary Care Director through the Service line under which GeriPACT resides.

(3) Designate the VA medical facility GeriPACT Director, who may be the VA medical facility Director of Primary Care or the VA medical facility Chief of GEC.

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

(1) Working with the VA medical facility Chief, Primary Care Service to establish and maintain appropriate service agreements. **NOTE:** *For more information on VA medical facility Chief, Primary Care Service, see VHA Handbook 1101.01(1) Patient Aligned Care Team, dated February 5, 2014.*

(2) Ensuring complete, accurate and timely GeriPACT workload reporting to the VA medical facility Director. (See Appendix B.)

(3) Communicating mission and goals, outcomes, resource needs and recommended sources, noteworthy accomplishments and urgent issues and options for addressing them, to VA medical facility leadership, staff and relevant clinical services on a regular basis.

(4) Ensuring appropriate overall panel capacity is maintained based on local patient complexity. (See Appendix C.)

(5) Ensuring that the GeriPACT program fully meets the standards for PACT programs. (See VHA Handbook 1101.01(1).)

(6) Ensuring the quality assurance program for GeriPACT encompasses both required PACT metrics and the VHA quality indicators that target frail elderly Veterans. (See Appendix D.)

6. TRAINING

There are no formal training requirements associated with this directive.

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

8. REFERENCES

- a. 38 U.S.C. § 7301(b).
- b. VHA Handbook 1100.19, Credentialing and Privileging dated October 15, 2012.
- c. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT), dated February 5, 2014.
- d. VHA Handbook 1140.04, Geriatric Evaluation and Management Procedures, dated November 28, 2017.

CHARACTERISTICS OF GERIATRIC PATIENT ALIGNED CARE TEAM TARGET POPULATION

Acceptable inclusion criteria include but are not limited to the following:

1. A combination of multiple medical, functional or psychosocial concerns, characteristically associated with advanced age, that is likely to benefit from assessment and management through an interdisciplinary team approach. **NOTE:** *Age should not be a defining determinant of the target population, but of note is that geriatric syndromes reside primarily in the geriatric population; a Veteran of any age may have need for the Geriatric Patient Aligned Care Team (GeriPACT) program.*
2. One or more geriatric syndromes. Examples of geriatric syndromes include:
 - a. Frailty and Sarcopenia.
 - b. Delirium.
 - c. Falls.
 - d. Disorders of gait and balance.
 - e. Incontinence of bowel or bladder.
 - f. Dementia or Cognitive Impairment.
 - g. Depression.
 - h. Polypharmacy.
 - i. Malnutrition and unintended weight loss.
3. Documentation of persistent suboptimal outcomes while managed in current Patient Aligned Care Team (PACT) (e.g., elevating requests for PACT visits, frequent Emergency Room visits, repeated hospitalizations) and a realistic potential for improvement if managed in GeriPACT.
4. Elder abuse, neglect or self-neglect.
5. Risk for long term care placement or concerns about ongoing independence in living arrangements, including acknowledgement of potential caregiver strain or needs for caregiver education, support and services.
6. Impending disability with potentially alterable health risks.
7. Multiple chronic diseases.

WORKLOAD REPORTING

1. Geriatric Patient Aligned Care Team (GeriPACT) is identified for the purposes of clinic workload capture and cost by Decision Support System Identifier (Stop Code) 350, "GeriPACT." Each GeriPACT encounter must be recorded with Stop Code 350 and an Evaluation and Management (E&M) Current Procedural Terminology (CPT) code.
2. Geriatric Evaluation can be done within GeriPACT and captured with the Healthcare Common Procedure Coding System (HCPCS) code, S0250.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

1. Geriatric Patient Aligned Care Team (GeriPACT) is subject to many of the same performance metrics as Patient Aligned Care Team (PACT). GeriPACT performance on certain population-based clinical performance metrics (e.g., hemoglobin A1c lipid and blood pressure control, referral for exercise for obesity) is not reflected in host sites' and Veterans Integrated Service Networks (VISNs') performance because Veterans over a certain age (usually age 70 or 75 years) were excluded from the summary calculations when the original validation studies for the measures included insufficient numbers of subjects above a specified age. Such exclusion must not be construed as clinical guidance; appropriate clinical assessment and monitoring is at the discretion of the clinician based on the individual Veteran. The GeriPACT provider's clinical judgment encompasses decisions in the context of risks, benefits, burdens and prognosis for remaining life expectancy. The Veteran's preferences and goals of care must also be respected and included in clinical decisions.

2. "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 Veterans Health Administration (VHA) Office of Analytics and Performance Integration and Department of Veterans Affairs (VA) medical facilities' and VISNs' performance in achieving the goals set for them. Data may be tracked through the Electronic Quality Management tool at: <https://eqm.va.gov/COR/#/dashboard/provider>. **NOTE:** *This is an internal VA website that is not available to the public.*

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

4. Reporting of Geri PACT quality assurance and performance improvement data will follow the VA medical facility reporting structure to leadership.

PANEL CAPACITY DETERMINATIONS

Because of the complexity of the patients served in Geriatric Patient Aligned Care Team (GeriPACT), the pro-rated full-time panel size of a physician geriatric provider must be negotiated locally and based on the complexity of the local patient population and usually set at 2/3 of the panel capacity set for the Department of Veterans Affairs (VA) medical facility's physician Patient Care Provider (PCP); see VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT), dated February 5, 2014. For non-physician geriatric providers, the pro-rated full-time panel size usually set at 2/3 the panel capacity set for the VA medical facility's independent non-physician PCPs. Panel sizes may be adjusted to reflect use of virtual care and case management.