

UNIFORM GERIATRICS AND EXTENDED CARE SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive defines minimum clinical requirements for VHA Geriatrics and Extended Care (GEC) Services. The inclusion in [38 CFR 17.38 - Medical benefits package](#) (hereinafter the VA Medical Benefits Package) of home health services authorized under Title 38 United States Code (U.S.C.) 1717 and 1720C, hospice care, palliative care, institutional respite care, and noninstitutional extended care services (including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care) that Department of Veterans Affairs (VA) furnishes on an outpatient basis as alternatives to institutional extended care (nursing home care) reflects a Congressional intent that all enrolled Veterans have access to these GEC services. This directive provides a rationale and description for each GEC program component to be implemented nationally, ensuring that VA medical centers' GEC programs are suitably organized, staffed, and integrated with other services, particularly Patient-Aligned Care Teams (PACT) and are Veteran-centric. This directive clarifies these services' integration within the VHA GEC continuum of care for all ages of Veterans including seriously injured Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) Veterans. It also outlines caregiver support services essential to maintain high-risk Veterans in the least-restrictive environment, because families/caregivers (traditional and non-traditional) are essential partners in the care of Veterans needing assistance with daily care (people with disabilities and/or frail older adults).

2. SUMMARY OF MAJOR CHANGES: This revised VHA policy updates VHA Handbook 1140.11, dated November 4, 2015, by correcting the programs that are subject to copayment and updating the list of programs that need to be available to Veterans in accordance with the medical benefits package.

3. RELATED ISSUES: VHA Handbook 1140.01, VHA Handbook 1140.02, VHA Handbook 1140.3, VHA Handbook 1140.04, VHA Handbook 1140.5, VHA Handbook 1140.6, VHA Handbook 1140.07, VHA Handbook 1140.08, VHA Handbook 1140.09, VHA Handbook 1140.10, VHA Handbook 1140.02, VHA Handbook 1140.3, VHA Handbook 1141.01, VHA Handbook 1141.02, VHA Handbook 1141.03, VHA Handbook 1142.02, VHA Handbook 1145.01, VHA Handbook 1160.01, VHA Handbook 1173.14, VHA Handbook 1173.17, VHA Handbook 1176.01.

4. RESPONSIBLE OFFICE: The Office of Patient Care Services, Office of Geriatrics and Extended Care (10P4G) is responsible for the contents of this VHA directive. Questions may be referred to 202-461-6770.

5. RESCISSION: VHA Handbook 1140.11, dated November 4, 2015, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October, 2021. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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UNIFORM GERIATRICS AND EXTENDED CARE SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. PURPOSE

This Veterans Health Administration (VHA) directive defines minimum clinical requirements for VHA Geriatrics and Extended Care (GEC) Services. The inclusion in the Department of Veterans Affairs (VA) Medical Benefits Package of home health services authorized under Title 38 United States Code (U.S.C.) 1717 and 1720C, hospice care, palliative care, institutional respite care, and noninstitutional extended care services (including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care) that VA furnishes on an outpatient basis as alternatives to institutional extended care (nursing home care) reflects a Congressional intent that all enrolled Veterans have access to these GEC services. This directive provides a rationale and description for each GEC program component to be implemented nationally, ensuring that VA medical facilities' GEC programs are suitably organized, staffed, and integrated with other services, particularly Patient-Aligned Care Teams (PACT). This directive clarifies these services' integration within the VHA GEC continuum of care for all ages of Veterans including seriously injured OEF/OIF/OND Veterans. It also outlines caregiver support services essential to maintain high-risk Veterans in the least-restrictive environment because families/caregivers (traditional and non-traditional) are essential partners in the care of Veterans needing assistance with daily care (people with disabilities and/or frail older adults). **AUTHORITY:** 38 U.S.C. 1717, 1720C and 38 CFR 17.38.

2. BACKGROUND

a. VHA's current approach to Geriatrics and Extended Care Services can be traced to various discrete processes and events unfolding over the past 80 years: VHA's development of nursing home practices; VHA's adoption of geriatric assessment (matching Veteran needs and expectations of functionality and independence to the services provided); VHA's embrace of non-institutional and other Veteran-centric approaches to extended care; and recent acceptance of a new GEC Strategic Plan in fiscal year (FY) 2009.

b. The first of these, as chronicled in 1967 by the Congressional Committee on Veterans Affairs (see paragraph [40.g.](#)), was the creation of the Veterans Administration in 1930 from its forerunner, the Bureau of Veterans Affairs (BVA). BVA was a confederation of state and federally-operated residential programs for Veterans who had sustained significant physical and/or psychological injuries and were unable or unwilling to reside in the community at large. As these Veterans aged and their chronic conditions took rising tolls on their health and functional abilities, their original requirements for food and shelter were compounded by the need for support in activities of daily living (e.g., dressing, bathing, toileting, mobility, etc.). As a result, VA, as the steward for these individuals, became the first national system of nursing homes: residential, institution-based programs for addressing, in a congregate setting, the self-

care needs of those unable to provide for themselves due to chronic disease and disability.

c. The second evolutionary step took place half a century later, by which time VA had grown from a system of nursing homes into one of hospitals (most with co-located nursing homes) allied with schools of medicine. In the late 1960s visionary VA leaders recognized that the aging of Veterans of World War II would soon present VA with an unprecedented challenge: care for an enormous population of predominantly elderly males. In response, a system of “Geriatric Research, Education, and Clinical Centers” (GRECCs) was initiated in VA in 1975 specifically to foster investigations concerning health and disease in aging, to develop improved approaches for caring for the elderly, and to share these developments among VA clinicians and future health providers. GRECCs adopted, refined, and validated a team-based variation of “geriatric assessment:” an approach for geriatric care pioneered by Dr. Marjory Warren in the 1940s in Great Britain consisting of systematic, multidisciplinary determinations of frail, dependent elderly undertaken to restore function and quality of life and halt or slow additional decline. This was the origin of Geriatric Evaluation and Management (see paragraph [40.n.](#)); to further facilitate VA-wide adoption of this patient-centric approach to care, several “Interdisciplinary Team Training” programs were initiated. Thus began the transition in VA nursing homes, spanning over three decades and still underway, from programs of depersonalized custodial care to programs of Veteran-centric restoration to the most functional state attainable by the Veteran.

d. In 1998 VHA’s Under Secretary for Health appointed a Blue Ribbon Panel to compare VHA’s largely nursing home-based system of extended care to the more diverse blend of residential and community-based extended care programs increasingly becoming available in the private sector. That panel’s report, “VA Long Term Care At The Crossroads” (see paragraph [40.i.](#)) led to several landmark provisions in Public Law 106-117, The Veterans Millennium Healthcare and Benefits Act (see paragraph [40.a.](#)) including:

(1) VA’s obligation to provide nursing home care to certain high-priority Veterans, and to maintain the system-wide capacity to provide that service at the 1998 level;

(2) Certain non-institutional extended care services (geriatric evaluation, adult day health care, home-based primary care, purchased skilled home care and homemaker/home health aide services; non-institutional hospice care and respite care) became part of the VA Medical Benefits Package (see paragraph [40.h.](#)), to ensure that all enrolled Veterans for whom it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual in accord with generally accepted standards of medical practice, have access to these noninstitutional extended care services; and

(3) A new algorithm for determining need for nursing home care beds in State Veterans Homes (SVH) was introduced, leading to unprecedented growth in number and size of these programs over the ensuing decade, and emergence of SVH as the dominant provider (based on number of Veterans receiving care in SVH, Community

Nursing Homes [CNH], and Community Living Centers [CLC] per year) for VA-supported institutional long term care.

e. A GEC Strategic Plan for VHA (see paragraph [40.i.](#)) was approved in 2009 by the Acting Under Secretary for Health. The vision for GEC in VHA that this strongly field-influenced Plan proposed to achieve was “VA will be the national leader in providing, improving, evaluating, teaching and researching excellence in geriatrics and extended care that is Veteran centered, integrated, and informed by individual preferences for settings that are safe, affordable, and as home-like as possible.” The Plan’s four goals are to:

(1) Provide GEC services that are Veteran-centric;

(2) Offer a uniform set of GEC services system-wide;

(3) Develop and maintain an adequately prepared and sized workforce to deliver the preceding two goals; and

(4) Continuously improve the quality of VHA’s provision of GEC services through clinical- and evidence-based tracking and benchmarking.

f. The development and dissemination of the present document is Recommendation #33 of that Strategic Plan. As such, the contents of this directive reflect VHA’s vision for geriatrics and extended care programs as described in that Plan.

g. The GEC program and services’ requirements included in this directive have been developed in tandem with and are complementary to the Universal Services Task Force’s recommendations (see paragraph [40.g.](#)), that drove many of the initiatives undertaken at the direction of the Secretary of Veterans Affairs to “transform” VA and VHA health care, beginning in FY 2010. The requirements of VHA Handbook 1101.01, Uniform Mental Health Services in VA Medical Centers and Clinics, have also served as a model in the development of this directive. The services described in this directive are therefore integrated and coordinated with other VA health care components. Although this directive focuses on GEC services, it does so within VHA’s comprehensive, integrated health care system.

h. This directive does not replace, change, or supersede existing statutory and regulatory criteria governing the described programs including eligibility and enrollment criteria. Because these criteria and other guidelines may vary among programs, VHA employees are encouraged to become familiar with them for each of the programs discussed in this directive and to consult their respective VHA program office or business office as needed.

3. DEFINITIONS

a. **Geriatrics.** Geriatrics refers to the diagnosis and treatment of medical and functional conditions encountered with the greatest frequency in Veterans of advanced age (historically and arbitrarily often chosen as 65 years), whose presentation,

diagnosis, and management are made more complex by physiological changes inevitable with advancing age and by biopsychosocial factors that are prevalent among older adults.

b. **Extended care**. Extended care refers to the range of residential and community-based programs available for supporting, with maximum safe independence, individuals who experience compromised self-care ability due to accumulated chronic diseases, injuries and resulting disability, regardless of age. A newer term, essentially equivalent to “extended care,” is “Long Term Services and Supports.”

c. **Veteran-centric Care** (also termed “patient-centered”) care is a fully engaged partnership of Veteran, caregivers, family and health care team, established through continuous healing relationships and provided in optimal healing environments, in order to improve health outcomes and the Veteran’s experience of care.

4. POLICY

Except as otherwise provided in 38 CFR 17.37, it is VHA policy that every enrolled Veteran is eligible to receive care described in the VA medical benefits package (38 CFR 1738) if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice (see paragraph [40.h.](#)).

5. REQUIREMENTS

a. The VA medical benefits package includes a variety of VA-provided and VA-purchased programs overseen by the Office of GEC, and described in greater detail in paragraphs 12-17 below. These programs include:

(1) [Geriatric Evaluation](#) (which may be delivered through [Geriatric Evaluation and Management](#), [GeriPACT \(formerly Geriatric Primary Care\)](#), [Home-Based Primary Care](#), and other programs);

(2) [Adult Day Health Care](#) or [Community Adult Day Health Care](#);

(3) [Purchased Skilled Home Care](#);

(4) [Homemaker/Home Health Aide](#);

(5) [Home-Based Primary Care](#);

(6) [Respite Care](#);

(7) [Hospice and Palliative Care](#) (in all settings);

(8) [VA Community Living Center](#) or [Community Nursing Home \(see Paragraph 5b below\)](#);

(9) [Community Residential Care \(CRC\)](#);

- (10) [Geriatric-Patient Aligned Care Team](#) (GeriPACT, formerly termed Geriatric Primary Care);
- (11) [Medical Foster Home](#) (MFH);
- (12) [Veteran-Directed Home- and Community-Based Services](#) (VDHCBS);
- (13) [Geriatric Consultation](#);
- (14) [Dementia Clinic](#);
- (15) [Geriatric Problem-Focused Clinic](#);
- (16) [Acute Care for the Elderly](#) (ACE);
- (17) Hospital at Home; and
- (18) [Dementia](#) and non-Dementia [Care Management](#) (including [Transition Management](#));

b. The Secretary must provide nursing home care which the Secretary determines is needed (1) to any Veteran in need of such care for a service-connected disability, and (2) to any Veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more (this includes Veterans who have a service-connected rating of total disability based on individual unemployability (TDIU)).

c. The following programs are subject to the copayment for Veterans who are not exempted:

- (1) Adult day health care—\$15.
- (2) Domiciliary care—\$5.
- (3) Institutional respite care—\$97.
- (4) Institutional geriatric evaluation—\$97.
- (5) Non-institutional geriatric evaluation—\$15.
- (6) Non-institutional respite care—\$15.
- (7) Nursing home care—\$97

d. The following program is exempt from the copayment for extended care in all cases: Hospice in any setting (**NOTE:** *This exemption does NOT apply to Outpatient Palliative Care*).

e. Two GEC programs are not clinical services but organizations of VA- and non-VA providers committed to optimizing care and well-being for dependent and elderly Veterans in their geographical areas. Each VISN should ensure the following programs (described below in paragraphs 16 and 31) are operational within their catchment areas:

- (1) Hospice-Veteran Partnerships (see paragraph [16](#), below); and
- (2) Veteran-Community Partnerships (see paragraph [31](#), below).

f. Qualified and competent staffs are necessary to deliver care in GEC programs. This directive specifies the professions providing the described services, but does so with the expectation that each staff member possesses the appropriate level of training and credentialing or clinical privileging, and has demonstrated and maintained proficiency in the competencies required. For example, the American Geriatrics Society has developed and published minimum geriatric competencies for each of the healthcare professions likely to be involved in the care of elderly Veterans, and for each set of competencies, one or more corresponding professional organization(s) has endorsed the competencies (see [40.b.](#)).

g. Because VHA is responsible for health care to a defined population, it is accountable for ensuring timely access to quality care for all Veteran patients, established and new.

h. The fulfillment of VHA's commitment to Veteran-centric care requires that Veterans be well informed about their options and be (with involvement of a surrogate if necessary) an active member of their care planning teams. When health care choices must be made and a Veteran lacks decision-making capacity and is unlikely to regain it within a reasonable period of time, a surrogate decision-maker is necessary. See [38 CFR 17.32\(3\) \(e\)](#). Every VHA clinical employee is responsible for ensuring that each patient (and, as appropriate, every surrogate decision-maker) knows and understands his or her care options and is provided access to information necessary for selecting among them.

i. Veterans typically present with multiple health problems and the needed services must not be set up in isolation. Effective communication and coordination among programs and services is an absolute necessity.

j. This directive defines requirements for Geriatrics and Extended Care services that should be provided as clinically indicated at VA medical centers and Community-Based Outpatient Clinics (CBOCs).

(1) Multi-Specialty CBOCs offer both primary and mental health care and two or more specialty services physically on site; and

(2) Primary Care CBOCs offer both primary care and mental health care and may offer support services such as pharmacy, laboratory, and x-ray.

k. GEC services may be provided by appropriate VA medical center staff, by telemedicine modalities, by referral to other VA facilities, or through non-VA care mechanisms such as sharing agreements, national or local contracts, and individual authorizations to the extent that the Veteran is eligible.

l. This directive does not describe every possible programming variant intended for frail, dependent, or chronically ill Veterans that may be or may become appropriate and effective. VHA system improvements and redesign are greatly dependent on field-initiated innovations; and sites are strongly encouraged to expand services beyond this directive's specifications to enrich their GEC programming, in accordance with relevant statutory and regulatory authority, local challenges, resources, and opportunities.

m. This directive's program descriptions are not comprehensive (leaving that for the Directives and Handbooks referenced in each section), but offer:

(1) Basic program specifics, including whether or not the program must be provided and

(2) Background information, to permit and facilitate each health system and point of care to optimize each particular program according to Veteran needs, staffing, community resources, and other local factors.

6. IMPLEMENTATION

a. VA Central Office recognizes that local and regional issues may affect the implementation of the requirements specified in 5.a.(1)-(8) above. Potential barriers to implementation include (but are not limited to):

(1) Space limitations within VA medical facilities;

(2) A relative lack of availability in certain regions of clinicians with appropriate GEC experience and/or expertise who could be recruited to the VA;

(3) Difficulties in meeting information technology needs;

(4) Veteran travel distances; and

(5) Limitations in the availability of community-based providers offering services using a sharing agreement, national or local contracts, or individual authorizations to the extent that the Veteran is eligible; and the time required developing contracts or other arrangements with local provider organizations.

b. Each VISN must notify the Deputy Under Secretary for Operations and Management (10N) through the Office of Geriatrics and Extended Care Operations (10NC4) of any required services within this directive that are not available and not being delivered, and are not expected to begin being available and delivered through available and projected resources, within two years of this directive's issuance; and must submit a proposal for clinical program restructuring prior to taking any action

toward reduction or closure of any required program. These notifications should specify:

(1) The service(s) that cannot be delivered and the facility(ies) affected;

(2) The resources needed to rectify the situation and how they will be secured. These may include medical care funds, medical facilities funds, informatics resources, legal support for contracting, or other resources; and

(3) Timetables and milestones for adding/restoring the service.

c. The Deputy Under Secretary for Operations and Management will respond to the applicant site within 30 days of receiving such a request and specify reporting expectations that will apply until such time as the situation is resolved.

7. STRUCTURE AND GOVERNANCE OF GEC SERVICES

a. Each VISN must include a GEC representative (herein referred to as the GEC Point of Contact, or GEC POC) as a member of its principal decision-making body (e.g., Executive Leadership Council or the equivalent). In addition to fulfilling the responsibilities accompanying membership on this Council, the GEC POC serves as:

(1) An advocate for GEC programs;

(2) A subject matter expert on GEC and GEC-related topics; and

(3) The VISN liaison with VA Central Office on GEC-related topics.

b. VISNs are strongly encouraged to empower the VISN GEC representative to regularly convene, virtually or face to face, a group consisting of a representative named by the Director or Chief of Staff from each of the medical centers or health care systems in the VISN. Representatives should have authority over or at least familiarity with all of the GEC programs at their parent sites. The group's function is to:

(1) Coordinate clinical activities;

(2) Standardize reporting;

(3) Address shared challenges; and

(4) Facilitate information exchange between the VISN and its GEC programs.

c. The individual described in paragraph 7a needs to be provided the resources necessary to effectively discharge the assigned responsibilities of coordination, communication, and representation. These include (but are not limited to):

(1) Time sufficient for fulfilling expectations of the position (i.e., avoidance of "collateral assignments" that obligate the individual to fulfil new obligations without commensurate relief of existing duties);

- (2) Administrative support (e.g., secretarial and analytical); and
- (3) Travel support (for regular in-VISN site visits).

d. In order to bring the appropriate level of clinical insight and organizational efficacy to the position, each GEC POC should be a health professional with geriatrics/extended care and administrative experience.

8. RESPONSIBILITIES

a. **Deputy Under Secretary of Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management (10N) is responsible for:

- (1) Communicating GEC policies and other information relevant to GEC to the VISNs;
- (2) Ensuring that GEC-related performance expectations are fulfilled; and
- (3) Communicating information from VA medical facilities to 10P4 and 10P4G.

b. **Office of Geriatrics and Extended Care Policy and Services.** The Office of Geriatrics and Extended Care (GEC) Policy and Services (10P4G) is responsible for:

- (1) Strategic planning concerning the agency's current and projected management of elderly and chronically disabled Veterans;
- (2) Establishing national GEC policies in accordance with Veterans' needs and the needs and priorities of the agency;
- (3) Setting GEC program standards; and
- (4) Providing subject matter expertise to the development of the responses from VHA and VA to official requests for information regarding aging Veterans, their health care needs, and the VA programs addressing them.

c. **Office of GEC Operations.** The Office of GEC Operations (10NC4) is responsible for:

- (1) Tracking and optimizing GEC program performance and
- (2) Advising the Under Secretary for Health on the extent to which clinical care and services are being delivered, consistent with policy, on behalf of Veterans.

d. **Veterans Integrated Services Network Director.** VISN Directors are responsible for:

(1) Communicating to their VA medical facilities GEC policies, guidance, and other GEC-related information as shared by the Deputy Under Secretary of Health for Operations and Management;

(2) Reporting workload information specific for each GEC program or service in a manner suitable for analysis and comparison;

(3) Appointing and supporting a GEC POC (as described in [paragraph 7](#)) and a VISN Dementia Committee (described in [paragraph 18.c.\(1\)](#)); and

(4) Reporting to 10N on temporary or sustained shortcomings in availability or delivery of required GEC services as described in [paragraph 6.b](#).

e. **VA Medical Facility Director.** VA medical facility Directors are responsible for:

(1) Ensuring the VA medical facility and its associated SC abide by policies communicated to the VA medical facility by the VISN Director.

(2) Ensuring there is a plan for providing necessary dementia care coordination as described in [paragraph 18e](#). Each VA medical facility should designate one individual to represent its GEC programs to the VISN, as described in [paragraph 7a](#) above.

9. GERIATRIC WORKFORCE ADEQUACY

a. The April 2008 Institute of Medicine report titled “Retooling the Healthcare Workforce for an Aging Society” (see [paragraph 40k](#)) provides compelling and extensive evidence that the US health care workforce is insufficiently prepared in both numbers and expertise to adequately address the health care needs of the growing proportion of the population that is of advanced age. A follow-up July 2012 Institute of Medicine report titled “The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?” documented the critical shortage of healthcare professionals prepared to address the mental health needs of the aging population (see [paragraph 40.i](#).) VA faces a corresponding challenge: the number of Veterans over age 65 grew from a few hundred thousand in 1970 to nearly 10 million by 2000 (nearly 37 percent of all Veterans) and in 2011 numbers approximately 9.2 million (nearly 41 percent). Veterans age 75 and over have risen from 15 percent of the total among Veterans in 2000 to over 21 percent presently. The number age 85 and over has increased from 432,000 to over 1.39 million in the same time span, yet the number of geriatrics specialists in various healthcare disciplines has been on flat or declining trajectories for over a decade. As a result vulnerable elderly healthcare needs in VHA continue to be borne almost exclusively by non-specialists, with specialists (where available) providing guidance, co-management, and (for the most challenging cases) direct care.

b. In light of the above, the 2009 GEC Strategic Plan’s third Goal, to “achieve an adequately educated and equipped workforce” for meeting the elderly and disabled Veteran population’s health and care needs, remains a priority consideration for GEC and VHA. Attempts to articulate a consolidated, strategic approach for addressing this concern continue to evolve, and customarily include elements of employee education,

mid-career specialization, recruitment and retention incentives, targeted employment of former trainees, and development of clinical approaches that optimize the contributions of clinicians with geriatric expertise.

10. STAFF DEVELOPMENT AND EDUCATION

a. As described in more detail in paragraph 19 below, VA operates 20 Geriatric Research, Education, and Clinical Centers ([GRECCs](#)) in 18 of the 21 VISNs. GRECCs' education activities primarily target staff and health trainees of the host VA and VISN, and secondarily community providers. Programs include grand rounds series, short-duration seminars, full- or multi-day continuing education programs, computer- and web-based instruction, mini-fellowships/mini-residencies, satellite and audio-teleconferences (both in real time and after the original presentations), and wide dissemination of print materials such as newsletters, pocket cards, and compendia of noteworthy literature. Thielke et al. (see paragraph [40.p.](#)) reported that in the period 1999-2009 over 14,000 teaching conference sessions on geriatrics topics were provided by GRECCs on behalf of nearly a quarter million learners. About 60,000 learners participated in approximately 1,300 national and regional GRECC conferences during the same time period. Information on individual GRECCs' educational programs may be found at http://www.va.gov/GRECC/GRECC_Educational_Events_and_Products.asp.

b. Several thousand GRECC medical and associated health trainees each year participate for weeks to months in interdisciplinary team rounds, clinics, and home visits in geriatrics. Although this type of learning experience is largely limited to sites with GRECCs, the enthusiasm trainees consistently express for these experiences suggests that expansion of these learning opportunities to non-geriatrics staff at sites without a co-located GRECC should receive serious consideration in order to enhance geriatrics knowledge and skills in the general VHA health clinician pool.

c. VA's Employee Education System (EES) frequently partners with GRECCs to arrange and accredit geriatrics continuing education offerings. From 1999-2009, about 130 GRECC programs were offered in partnership with EES to about 5,100 learners. During the same period, 430 geriatrics programs were provided, independent of GRECC, to about 15,000 learners. EES programs are broadly advertised through a variety of internal VA media; their learning calendar is accessed at <http://vaww.sites.lrn.va.gov/vacatalog/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

d. Education of VA nurses is generally administered independently from EES. At each VA medical facility a nurse leader responsible for nursing education (often an Associate Chief Nurse for Nursing Education) is responsible for identifying, developing, and conferring clinical nursing competencies, often assisted and supported by a local Evidence-Based Practice Council.

11. PREVENTIVE CARE

a. The goals of preventive geriatrics are not only reduction of premature morbidity and mortality but preservation of maximal quality of life and function. Preventive health in advanced age therefore consists of efforts to promote lifestyle behaviors that avoid onset and minimize the progression of chronic diseases and encourage heightened sensitivity to environmental conditions in order to minimize the likelihood of incidents that may be particularly hazardous to an older individual.

b. U.S. Preventive Services Task Force (USPSTF) and VA National Center for Health Promotion and Disease Prevention (NCP) have disseminated recommendations on screening for some specific disorders that are of particular concern among frail and elderly Veterans.

(1) USPSTF screening recommendation statements are available at:
<http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

(2) VA NCP screening recommendation statements are available at:
http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp. **NOTE:**
This is an internal VA Web site that is not available to the public.

c. Development of each older Veteran's preventive health recommendations needs to be a personalized and Veteran-centric process.

(1) All clinical preventive services recommendations should balance benefits and harms. For some preventive services recommendations, the evidence underlying the recommendation may be insufficient in regard to older adults, in which case recommendations may be extrapolated from evidence derived in younger populations. Veterans and their providers should consider the Veteran's individual health status and clinical situation in deciding whether to follow a specific preventive service recommendation.

(2) Adherence to preventive health recommendations needs to account for diminished life expectancy. For example, recommending fecal occult blood screening for someone with advanced congestive heart failure, or performing a mammogram on an elderly female who is in an advanced stage of dementia, may not be clinically indicated.

d. Preventive health recommendations relevant to individuals of advanced age are reflected in the "Frail Elderly" quality indicators tracking care of "vulnerable" primary care Veterans age 75 years and over (see paragraph [40.o.](#)). These measures were derived from the "Assessing Care of Vulnerable Elderly" (ACOVE) set developed, validated, and disseminated by the RAND Corporation and UCLA School of Medicine (see [40.m.](#)). They are evidence-based and focus on function and quality of life. They are designed to reflect on providers' timely attention to falls, functional ability, urinary incontinence, advance directives, discharge planning, mobility, and other parameters important to the health, healthcare and function of older Veterans. They also reflect the importance of Veteran-centricity in health management by addressing identification of a

surrogate healthcare decision-maker and continuity of care among different venues and providers.

e. Review of every older patient's intake of pharmaceutical agents is an essential component of preventive geriatric health. There are numerous reports published in the professional literature reflecting high rates of inappropriate prescribing for older adults, attributable to a variety of causes, including: care by multiple independent providers (including simultaneous use of agents prescribed not only by a primary care provider, but also in urgent care, emergency room, and acute and long term care inpatient settings), resulting in use of multiple redundant or incompatible drugs; dosages that do not take into account age-related changes in distribution, kidney function, or metabolism, resulting in excessive dosages; use of agents found to be more prone to adverse effects in the elderly than recommended alternatives; and inadequate patient education about the intended prescribing regimens (e.g., timing, amount, food restrictions, etc.).

f. Comprehensive Geriatric Assessment (CGA--also termed "geriatric evaluation": see [12.a.](#), below) encompasses an all-inclusive functional, psychosocial, and medical evaluation, is customarily conducted by an interdisciplinary team and is the optimal basis for recommendation of tertiary preventive strategies for a geriatric patient.

g. All older Veterans, with the assistance of their providers and caregivers, need to be offered the opportunity to participate in shared decision making so that they can weigh the potential benefits and harms of screening and treatment versus a more conservative, symptom-based approach.

h. When a Veteran's cognition is impaired, family members, caregivers, and other designated surrogates need to be included in such discussions, pending the Veteran's consent.

12. GERIATRIC EVALUATION

a. Geriatric Evaluation (also termed "Comprehensive Geriatric Assessment" or CGA—see paragraph [11.e.](#) above) was one of the services explicitly added to the Medical Benefits Package by Pub. L. No. 106-117, 101 (see paragraph [40.a.](#)), because of its demonstrated success in reducing nursing home placement. Geriatric evaluation is a comprehensive, multidimensional assessment undertaken by a clinical team; followed by the development of an interdisciplinary plan of care. Details on geriatric evaluation are in VHA Handbook 1140.04, Geriatric Evaluation and Management (GEM) Procedures (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2237), or subsequent policy issue available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

b. Geriatric Evaluation in an outpatient setting may be undertaken by one of the outpatient geriatric programs described in paragraph 13 below, or may be requested by a patient's PACT; in their request for the service, the PACT will specify whether they

intend for the geriatric evaluation team to execute the plan of care recommended, or for PACT to fulfill the recommendations.

c. The findings from a Geriatric Evaluation undertaken in an inpatient setting will be communicated with the patient's PACT and coordinated with other plans for discharge and post-discharge care.

d. Geriatric Evaluation is a process, not a program. As such, provision of Geriatric Evaluation needs to be recorded with the secondary code S0250, regardless of the setting in which it occurs (unless it is provided as part of Home-Based Primary Care: see paragraph 12d(4) below). Settings in which it may be provided include:

(1) Inpatient or Outpatient Geriatric Evaluation and Management Clinic;

(2) Geriatric Primary Care (GeriPACT) Clinic;

(3) Geriatric Problem-Focused Clinic;

(4) Home-Based Primary Care (HBPC) (**NOTE: S0250 must NOT be coded for any of the HBPC stop codes. Workload for Geriatric Evaluation is credited for every HBPC admission automatically; entering S0250 results in redundant, inaccurate coding**); and

(5) Community Living Center (CLC).

e. Geriatric Evaluation must be available to all enrolled Veterans for whom it is determined by appropriate healthcare professionals that the service is needed to promote, preserve, or restore the health of the individual in accord with generally accepted standards of medical practice. Because not every Veteran who may benefit from Geriatric Evaluation will be admitted to CLC or to Home-Based Primary Care, VA health systems need to offer one or more additional alternatives for delivery of that service, such as Geriatric Primary Care/GeriPACT, Geriatric Specialty Clinic, or Inpatient or Outpatient GEM.

13. GERIATRIC CLINICS AND CONSULTATION SERVICES

Over 95 percent of Veterans receiving their health care from VHA and age 65 years and older are managed through primary care delivered in Patient-Aligned Care Teams (PACTs). A subset of older Veterans, and an even smaller proportion of younger Veterans with complex medical, functional, and behavioral needs, benefit from the input of clinicians with advanced training and experience in geriatrics. No single one of the following clinical services is itself a required service under the VA Medical Benefits Package, but each of the following may be a source for Geriatric Evaluation, which is a required benefit.

a. **Geriatric Evaluation and Management (GEM)**. A specialized program of services provided by an interdisciplinary team of health care professionals. GEM targets a group of predominantly older Veterans and others with medical complexity who will benefit clinically from these services. Details on GEM are found in VHA

Handbook 1140.04, Geriatric Evaluation and Management (GEM) Procedures, (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2237), or subsequent policy issue available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(1) GEM services may be provided in an inpatient or outpatient setting.

(2) GEM may serve as a means for delivery of the required “Geriatric Evaluation” service described in paragraph 12 above.

(3) The “evaluation” component of GEM consists of a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care.

(4) The “management” component of GEM consists of treatment, rehabilitation, health promotion, and psychosocial interventions necessary for fulfillment of the plan of care provided by key personnel including: geriatrics providers and nursing, social work, mental health, clinical pharmacy, rehabilitation, and administrative staff. When provided in the outpatient setting, the management component of GEM is equivalent to Geriatric Primary Care (see next section) and its workload reported accordingly.

b. Geriatric Patient-Aligned Care Team (GeriPACT), formerly termed Geriatric Primary Care: The longitudinal health care management of particularly challenging elderly and disabled Veterans in an outpatient setting, by a PACT whose panel is comprised predominantly of such patients and whose identifier in the Patient-Centered Management Module (PCMM; formerly known as *Primary Care Management Module*) contains *GERI* within its name. The GeriPACT is led by a provider with advanced expertise in geriatric care and team members with advanced skills in managing the longitudinal care requirements of patients whose multifaceted chronic care needs are made additionally complex by significant psychosocial, behavioral, and care coordination factors. More information on this program is found in VHA Handbook 1140.07, Geriatric Patient-Aligned Care Team (GeriPACT), or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(1) GeriPACT may serve as a means for delivering of the required “Geriatric Evaluation” service described in paragraph 12 above.

(2) Panel size: The GeriPACT’s expertise is targeted to the evaluation and management of the range of complex functional, cognitive, and psychosocial issues that particularly affect frail elderly Veterans. The relative scarcity of such expertise dictates that the GeriPACT’s efforts in longitudinal care are limited to those cases most in need of those advanced skills and knowledge, and the complexity of the cases requires a higher ratio of providers to patients. As such, VHA Handbook 1140.07 specifies that the panel for GeriPACT should not exceed two-thirds the recommended PACT panel size at the facility; and should be prorated according to the provider’s time assigned to

longitudinal care. Panel size should be calculated based on a provider's fractional time devoted explicitly to geriatric primary care. Time committed to fulfilling the role of "geriatrician specialist" (i.e., time spent addressing consultation requests and comanaging patients with PACTs) should not count toward the number of half-days of GeriPACT clinic on which panel size is pro-rated.

(3) Panel characteristics: The GeriPACT's panel is comprised of Veterans transferred from the panels of other PACTs and Veterans who have been assigned to the panel on the basis of one or more objective criteria (e.g., functional limitations and decline, multiple interacting chronic diseases, psychosocial complications to disease management); or from a registry focused on criteria selected by GPC leadership to identify high risk Veterans appropriate for GPC (see paragraph [32.b.\(3\)](#)). Veteran age should not be the sole criterion for assignment to GeriPACT.

(4) Provider characteristics: GeriPACT providers should have advanced training in care of frail elderly patients in collaboration with the interdisciplinary team. Advanced formalized training, such as a geriatric fellowship or certification as a gerontological nurse practitioner or clinical nurse specialist, is preferable but not required. The limited availability of geriatricians and their concentration in VA settings with strongly academic missions favors geriatrician/nurse practitioner (or /physician assistant) dyads that ensure continuity of care and access for patients to GeriPACT physicians who are likely to have additional clinical and educational obligations.

(5) Teamlet characteristics: The staffing pattern for GeriPACT needs to be no less than recommended for PACT. Family and psychosocial considerations (see paragraph 13b) and pharmacological complexities (see paragraph [11.e.](#)) among nearly all patients managed in GeriPACT dictate that staffing of social work and clinical pharmacist should likely be higher than those recommended for PACT generally. A mental health professional, although not part of the core teamlet, needs to part of every GeriPACT.

c. **Geriatric Problem-Focused Clinic.** Geriatric problem-focused clinic refers to any one of a number of specialty clinics (e.g., memory loss clinic, falls clinic, incontinence clinic, etc.) devoted to the assessment and management of a particular geriatric syndrome, such as falling, gait and balance disorders, failure to thrive, incontinence, memory loss, polypharmacy (see paragraph [11.e.](#)), depression, sleep disturbance, impaired cognition, or others. More information on this program may be found in VHA Handbook 1140.10, Geriatric Ambulatory Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

(1) Geriatric Problem-Focused (GPF) Clinic may serve as a means for delivering of the required "Geriatric Evaluation" service described in paragraph 12 above.

(2) At those points of care where a particular needed form of GPF Clinic is not available, input regarding the clinical guidance sought can in most cases be obtained by requesting a Geriatric Consultation (see paragraph 13d, following).

d. **Geriatric Consultation.** A geriatric consultation is the time-limited, problem-focused assessment of an inpatient or an outpatient by a physician or other independent provider with advanced training, certification, or extensive experience in geriatrics in response to a request for clinical advice on a specific clinical geriatrics issue, with or without the additional input of a team. Additional information on this program is found in VHA Handbook 1140.09, Geriatric Consultation, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

(1) Geriatric consultation may serve as a means for delivering of the required geriatric evaluation service described in paragraph 12 above.

(2) Geriatric consultation is initiated through the Computerized Patient Record System (CPRS). The response to the consultation request in CPRS generally consists of a written assessment and recommendation for management. Because several controlled trials in the professional literature report that outcomes stemming from geriatric consultation are significantly better when post-consult participation by the consultant occurs (also termed “co-management”), both the treating team and the consultant should consider for each case whether or not co-management would be in the Veteran’s better interest.

(3) VA healthcare systems may find it useful to assign responsibility for geriatric consultation to individuals or teams charged with other geriatrics programs, such as GeriPACT, Outpatient GEM, Inpatient GEM, CLC, or HBPC.

(a) When geriatric consultation is assigned to an outpatient program (e.g., GeriPACT or GEC Clinic), the outpatient program’s appointment management needs to take the additional workload of geriatric consultation into account when scheduling appointments and appointment length.

(b) When geriatric consultation is assigned to GeriPACT, the provider’s panel size needs to be adjusted commensurate with the time commitment for responding to geriatric consultations and co-managing patients.

(c) A Veteran co-managed by a community provider and only requiring VA prescription renewal is unsuitable for geriatric consultation referral on that basis alone.

14. NON-INSTITUTIONAL EXTENDED CARE

Non-institutional extended care programs have resulted in substantial reductions in nursing home placement and enhanced quality of life for Veterans receiving the service (see paragraph [40.i](#)). They facilitate Veterans’ independence in the least restrictive home-like environment, delay or prevent institutionalization through an interdisciplinary approach, and in many cases provide intensive caregiver support and respite, fostering the Veteran’s ability to remain in a less restrictive environment. **NOTE:** *Because many of these services are part of the VA medical benefits package, VISN and VA medical facility leadership must budget and consistently provide for sustained and appropriate*

support for the required non-institutional extended care programs' staffing and costs. If local resources are inadequate to fully meet the demand for these services, an Electronic Wait List must be kept and maintained, per VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=1&order=asc&orderby=pub_Number.

a. **Adult Day Health Care.**

(1) Adult Day Health Care (ADHC) is a form of non-institutional extended care that is available to all Veterans pursuant to the VA medical benefits package. The mandate for offering ADHC can be fulfilled by a VA-run program, or by contracting for Community ADHC (C-ADHC).

(2) ADHC and C-ADHC are therapeutically-oriented outpatient programs recommended by VHA providers, offering health maintenance, rehabilitative services, socialization, and caregiver respite and support (usually daytime, Monday through Friday) in a congregate setting, for Veterans meeting nursing home level of care. See VHA Handbook 1141.03, Adult Day Health Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number). Staffing for a VA-run ADHC Program must be adequate to meet the complex health, functional, cognitive, and psychosocial needs of the participating Veterans. The staff-to-Veteran ratio may vary, depending on the participating Veterans' care needs, but generally includes a program coordinator/director, medical facility Director, social worker, registered nurse, rehabilitation therapist (occupational, physical, or kinesiotherapy); recreation therapist, and dietician or dietary technician.

(3) VA may provide transportation for eligible participants to and from a VA-run ADHC or a contract-run ADHC under the authority in 38 U.S.C. 111A.

b. **Home-Based Primary Care.**

(1) HBPC is a form of non-institutional extended care that, as part of the VA medical benefits package, must be available to all Veterans who would benefit from it and who fulfill the inclusion criteria specified in VHA Handbook 1141.01, Home Based Primary Care, HBPC is comprehensive, longitudinal and interdisciplinary primary care delivered in Veteran's homes. Veterans who would especially benefit from HBPC are those at increased risk for hospitalization, nursing home placement, or emergency room utilization in the absence of the service. Full program requirements are described in VHA Handbook 1141.01, Home-Based Primary Care Program, or subsequent policy issue, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(2) The core interdisciplinary team for HBPC consists of a physician, nurse practitioner, or physician assistant; full time psychologist or psychiatrist, social worker; registered nurse; dietitian; and clinical pharmacist (see VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number).

(3) HBPC programs in highly rural areas may complete their interdisciplinary teams using a combination of a “VA core team” and contracted staff when low population density makes it difficult for VHA to employ all of the specified HBPC team members.

c. **Purchased Skilled Home Care (PSHC)** must be available to all Veterans for whom it is determined by appropriate healthcare professionals that the service is needed to promote, preserve, or restore the health of the individual in accord with generally accepted standards of medical practice. PSHC is a general term for VHA provider-ordered, in-home services including: home hospice and/or skilled nursing, and auxiliary health provider services. See VHA Handbook 1140.06, Purchased Home Health Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number; and VHA Handbook 1140.5, Purchased Hospice Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(1) The means for arranging payment for this service is a contract. A Basic Ordering Agreement may be used to facilitate entering into contracts. VHA GEC, in collaboration with other services/disciplines (e.g., PACT, Care Coordination/Home Telehealth, Social Work, Community Nursing, Mental Health, Rehabilitation Services, etc.) coordinates the provision of these home and community based services, oversees them to ensure compliance and quality requirements are met, and integrates them with other VA- and non-VA-provided supportive services.

(2) An alternative means for supporting this service is through a Veteran Directed Home and Community Based Services (VDHCBS) program, under which VHA contracts with a State Area Agency on Aging to provide Veterans at risk of nursing home placement with a flexible array of Veteran-selected in-home services coordinated for maintaining Veterans in their homes.

d. **Homemaker/Home Health Aide.** Homemaker/Home Health Aide (H/HHA) must be available to all Veterans for whom it is determined by appropriate health care professionals that the service is needed to promote, preserve, or restore the health of the individual in accord with generally accepted standards of medical practice, pursuant to the VA medical benefits package. HHA consists of VHA primary care provider-ordered personal care and related support services enabling frail or disabled Veterans, who would otherwise require institutionalization, to remain at home. See VHA Handbook 1140.06, Purchased Home Health Care, or subsequent policy issue,

available at

http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

e. **Respite Care.** Respite care is time-limited care provided for the purpose of helping the Veteran to continue residing primarily at home. Respite providers temporarily replace the caregivers to provide services ranging from supervision to skilled care needs. Respite care is part of the VA medical benefits package and so must be available to every enrolled Veteran for whom it is determined by appropriate health care professionals that the service is needed to promote, preserve, or restore the health of the individual in accord with generally accepted standards of medical practice. Respite care may be provided on inpatient units (acute or extended care), in community nursing homes at VA expense (see [15.d.](#)) or for outpatients through ADHC, H/HHA, and home respite services. Respite care may be purchased by contract. Home-based respite is the preferred option whenever possible because of the elevated risk for nosocomial infection and disorientation associated with even brief institutional placement. See VHA Handbook 1140.06, Purchased Home Health Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number and VHA Handbook 1140.5, Purchased Hospice Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

f. **Community Residential Care.** Community Residential Care (CRC) is the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred Veterans in an approved home in the community by the facility's provider. CRC offers an alternative to institutional placement for some Veterans. The Veteran is responsible for paying any charges by the community residential care facility, but VA provides the quality and safety oversight through a CRC program coordinator and one or more case managers. For more information, including eligibility requirements, see VHA Handbook 1140.01, Community Residential Care Program, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

g. **Medical Foster Home.** A medical foster home (MFH) is a private home in which a MFH caregiver (who must own or rent the MFH and reside there), with assistance from relief caregivers, provides a safe environment, room and board, supervision, and personal assistance, as appropriate for each Veteran. See VHA Handbook 1141.02, Medical Foster Home, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number. The choice to become a resident of a MFH is a voluntary one on the part of each Veteran, and the Veteran is responsible for paying the room and board charges of the MFH. VA healthcare personnel may assist a Veteran by referring such Veteran for placement in a MFH if:

(1) The Veteran is unable to live independently safely or is in need of nursing home level care;

(2) The Veteran must be enrolled in, or agree to be enrolled in, either a VA HBPC or VA Spinal Cord Injury homecare program, or a similar VA interdisciplinary program designed to assist medically complex Veterans living in the home; and

(3) The MFH has been approved in accordance with the terms of 38 CFR 17.73(d).

h. **Home Telehealth in Support of Non-Institutional Care.** Home Telehealth (HT) in support of non-institutional care involves the ongoing monitoring and assessment by VHA staff of selected Veterans' medical conditions through telehealth technologies to enhance Veterans' health and prevent unnecessary and inappropriate admission to institutional care—including nursing home placement. . HT is managed by a separate program office, VHA Telehealth Services. Details of this program and other areas of telehealth are provided on the VHA Telehealth Services Web site <http://vaww.telehealth.va.gov/pgm/ht/index.asp>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

15. INSTITUTIONAL EXTENDED CARE

a. VA supports institutional extended care, historically referred to as nursing home care, in three venues: VA owned and operated Community Living Centers (CLC – formerly known as VA nursing home care units), State-owned and operated State Veterans Homes, and care purchased by VA in community nursing homes. VA is authorized to provide nursing home care to all Veterans who need such care and who meet the minimum length of service requirement. VA is mandated to provide nursing home care to Veterans who need such care and who have a service-connected disability rated at 70 percent or more; based on a service-connected disability or unemployability; or those whose need for such care is for a service-connected disability. In addition, Veterans who are difficult to place due to spinal cord injury and other challenging conditions should be given consideration for CLC admission.

(1) Nursing home services are provided for Veterans whose health care needs are so extensive that they cannot be met in Veterans' homes or in outpatient clinics, but rather require the continuous skilled nursing and personal care best provided in an institutional setting.

(2) Each nursing home venue has its own unique set of characteristics. This variety allows each Veteran to be placed in a facility that is the best match for the Veteran's preferences and needs.

b. **VA Community Living Centers.** VA CLCs are federal facilities owned and operated by VA. CLCs reflect VA's commitment to provide care that is resident focused and enhances Veteran choice. CLC teams provide integrated, interdisciplinary care to address Veterans' interacting medical, functional, and psychosocial needs by staff with training and commitment to optimize resident quality of life.

(1) VA CLCs offer a dynamic array of services geared toward assisting Veteran residents to achieve the highest level of function or experience dignity and comfort in dying. Care is provided in a manner in which work practices, care practices and the environment of care reflect individual preferences and attention to age specific needs in a setting reminiscent of home.

(2) Services are customer focused, Veteran-centric, data driven, and reflect nursing home care that is future oriented (i.e., provision of service with an eye toward the Veteran's future).

(3) VA CLCs have been on a journey to transform the culture of care that recognizes that individuals thrive in a setting where the care goals include achievement of the highest level of function. Transformation includes:

(a) Work practices that encourage consistent assignment of staff and focus on staff empowerment through self-scheduling and increasing leadership roles in the delivery of personal care.

(b) Care practices that revolve around the resident being the driver of sleep/wake times; increased resident choice in meals; and honoring personal care and bathing practices.

(c) There is movement toward broader adoption of environments of care that look, feel, and smell homelike, limited to 10-12 residents and including private bedrooms, living room, kitchen, dining area, den/hearth room and no nurse stations; where the lighting and flooring are soothing and noise is at a minimum.

(4) A Veteran's access to VA CLC care will be impacted by the clinical need, the CLC's ability to provide the needed blend of particular services, and bed availability. VA CLC care is generally directed toward Veterans requiring short stay services, but longer stay services are also provided.

(5) Staffing requirements for CLC vary according to case mix and Veteran turnover, but the general expectation is that nurse staffing will be in accord with guidance contained in VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, or subsequent policy issue.

(6) CLC teams promote Veteran emotional well-being through collaborative assessment and treatment of mental disorders and addressing behavioral symptoms, often a reflection of unmet needs, through a balance of Veteran-centered behavioral, environmental, and pharmacological interventions. Each CLC should be staffed by at least 1.0 full-time equivalent (FTE) psychologist per 100 beds and have geriatric psychopharmacology treatment capacity available to meet the needs of its residents, , per VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, or subsequent policy issue, available at

http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

(7) Nursing home services in a VA CLC may be long stay (91 days or more), or may be short stay (90 days or less). Long stay is generally for dementia care, continuing care, mental health recovery, and spinal cord injury. Short stay is generally for respite care, rehabilitation, restorative care, continuing care, mental health recovery, dementia care, geriatric evaluation and management, skilled nursing care, and hospice (which may exceed the 90-day limit). Workload capture in CLC is according to the Treating Specialty to which the Veteran was admitted, as described in VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(8) Discharge planning from CLC needs to begin on the day of admission because discharge is usually a key goal of the CLC stay. Discharge planning needs to take into account the CLC resident's post-discharge support system (e.g., informal and formal caregiver support) in order to include adequate provision of an appropriate level and variety of services for addressing the remaining dependencies anticipated when the patient has maximized his or her function. Discharge planning needs to include safety assessment of the anticipated discharge destination and address potential risks for future injury as well as needs for durable medical equipment. Discharge planning must not only include the pharmaceutical regimen with which the CLC resident will leave, but also include attention to the focused education and confirmed uptake of information about the drug routine on the part of the resident and his or her caregiver. Finally, but no less importantly, discharge planning needs to include post-discharge healthcare planning, including ensuring adequate dietary intake and follow up appointments with non-VA providers and services, PACT, mental health, rehabilitation, and activities for promoting socialization and physical activity; as well as taking into consideration the transportation necessary for travel to and from these activities. See also paragraph [27](#).

c. **State Veterans Homes.** Each State Veterans Home (SVH) is owned and operated by its host state. By law, VA has no authority over the management or control of any state home. Each state defines its own eligibility and admission requirements for Veterans. The SVHs provide nursing home care and domiciliary care with a focus on long-stay services and adult day health care.

(1) SVHs may apply to VA for grants for purchase, construction, and/or renovation of SVHs, for which VA will pay up to 65 percent of allowable costs. The state must pay the balance of these costs.

(2) Following the construction of a new SVH, the state requests VA recognition. Recognition makes the SVH eligible for per diem payments from VA that is approximately one-third of the cost of care. VA pays a higher per diem for certain highly service-connected Veterans and Veterans in need of nursing home care for a VA adjudicated service-connected disability."

(3) VA surveys SVHs to ensure that VA standards are met and that the host state remains eligible for continued per diem payments. See VHA Handbook 1145.01,

Survey Procedures for State Veterans Homes (SVH) Providing Nursing Home and Adult Day Health Care, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(1) **Community Nursing Home Program.** VA purchases nursing home care through the Community Nursing Home (CNH) Program. CNH provides a broad range of nursing home services, including rehabilitation, respite, and hospice; and are available in many communities nationwide, enabling a Veteran to receive care near his/her home and family. See VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number. Veterans are referred to CNHs by the VA medical facility where the Veteran receives care. The duration of the arrangement is dependent on the reason for admission (e.g., post-acute rehabilitation vs. life stay) and the Veteran's service connection-based priority status (see [15.a.](#)). CNH may be authorized for any veteran who has been discharged from a hospital under the direct jurisdiction of VA and is currently receiving VA home health services.

(2) Payment for CNH must adhere to stipulations in VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

16. HOSPICE AND PALLIATIVE CARE

a. **Hospice and Palliative Care.** Hospice and Palliative Care (HPC) is a set of services authorized in the VA medical benefits package. **NOTE:** *Because of the time-critical nature of end-of-life care, use of the Electronic Wait List described in paragraph [14](#) is not allowed for HPC.* HPC needs to be available to enrolled Veterans in any suitable setting, as described in VHA Directive 2008-066, Palliative Care Consult Teams (PCCT), or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=1&order=asc&orderby=pub_Number.

b. Hospice and palliative care is a continuum of comfort-oriented and supportive services provided in home, community, outpatient, or inpatient settings for Veterans with advanced life-limiting disease. HPC's goal is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity to the greatest extent possible. HPC programs emphasize comprehensive management of the physical, psychological, emotional, social, and spiritual needs of the Veteran while also offering, as appropriate and as authorized by 38 U.S.C. 1783, support and bereavement counseling to eligible individuals, which may include members of the Veteran's immediate family, the Veteran's caregiver, or the individual in whose home the Veteran lived prior to dying.

(1) Palliative care emphasizes symptom control for life-limiting illness, but does not require a time-limited prognosis.

(2) Hospice is a palliative care mode for the Veteran diagnosed with a known terminal condition with a prognosis of less than 6 months. Hospice is a required service of the VA medical benefits package (see paragraph [40.h.](#)).

c. **Required HPC Elements.**

(1) Each VISN must designate a VISN Palliative Care Program Manager/Coordinator and a VISN Palliative Care Clinical Champion to provide administrative and clinical oversight, respectively, to the VISN's Palliative Care programs. The VISN needs to ensure the time and resources available to these two individuals are sufficient to:

(a) Coordinate the VISN-wide HPC program in accordance with VHA guidelines, including palliative care resource monitoring and workload, development and implementation of a quality improvement plan, and regular reports to VISN leadership;

(b) Identify and share palliative care best practices between the VISN and the private sector.

(c) Pain management, whether needed in response to symptoms of a terminal, life-limiting illness or for other causes, needs to be aligned with the principles and requirements articulated by the National Pain Management Office in VHA Directive 2009-053, Pain Management, or subsequent policy issue, available at [http://www.va.gov/vhapublications/publications.cfm?pub=1&order=asc&orderby=pub_number](http://www.va.gov/vhapublications/publications.cfm?pub=1&order=asc&orderby=pub_number;);

(d) Support development and activities of Hospice-Veteran Partnerships (see paragraph 16.c.(4) below);

(e) Facilitate VISN, VA medical facility, and CBOC staff development and palliative care education; and

(f) Serve as, or support the designation of another palliative care professional to serve as, a public spokesperson for End-of-Life issues, working collaboratively with VHA Public Affairs officials, communications offices, and leadership at the local, regional, and national levels. **NOTE:** *Communications training for this individual (e.g., speaking with media, public speaking, use of audiovisual aids, etc.) is encouraged.*

(2) The Palliative Care Consult Team (PCCT) is an interdisciplinary team of professionals from medicine, nursing, social work, psychology, chaplaincy and other providers as appropriate (no less than 0.25 FTE for each discipline), charged with responding to inpatient consultations for HPC, active case-finding for HPC, assisting in the development and maintenance of a HPC program for the facility, promoting HPC educational activities for all facility staff, and participating in HPC quality improvement activities for the facility.

(3) Facilities need to have a mechanism for identifying every Veteran appropriate for HPC and determining his or her specific care preferences. VHA facility staff needs to assist Veterans to obtain needed hospice services through referral or purchase as appropriate and to the extent the Veteran is eligible. Veterans needing hospice care may choose to receive such care through a non-VA payment source such as Medicare. However, if an enrolled Veteran needing hospice care services requests VA hospice care, the VA facility must provide it; this includes inpatient and home hospice care (see 38 CFR 17.36 and 17.38). See VHA Handbook 1140.6, Purchased Home Health Care (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1457), or subsequent policy issue; VHA Handbook 1140.3, Home Health and Hospice Care Reimbursement Handbook (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1139), or subsequent policy issue; and VHA Handbook 1140.5, Community Hospice Care: Referral and Purchase Procedures, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number.

(4) Hospice Veterans Partnerships (HVPs) are enduring networks of community hospice and VHA professionals, Veterans, volunteers, and other interested organizations working together to optimize access to quality services for Veterans through the end of life. HVPs provide leadership and technical assistance to improve Veterans' access to HPC across all sites and levels of care by: 1) educating State, county, and local hospice providers about Veterans' special needs and about VHA services and benefits; 2) maintaining awareness of community-based public and private hospice and palliative care assets, particularly with respect to Veterans and their families; 3) developing models for coordinating services for Veterans and families (e.g., sharing agreements, co-location of staff, providing telemedicine consultation); and 4) addressing issues regarding transfer of Veterans requiring hospice care from community hospitals and long-term care facilities.

(5) Palliative telemedicine consultation requires a qualified professional at the facility and support staff at the distal end who can arrange appropriate time and space for the Veteran, and staff who can provide technical support as needed. Use of telemedicine to support the delivery of HPC services is allowable and should be encouraged to expand access in settings remote from VA medical centers.

(6) HPC services in CBOCs are necessary in order to offer palliative care consultation and advanced care planning for Veterans with life-limiting illnesses through full- or part-time staffing, telemedicine with parent VA medical centers, or other alternatives (e.g., remote chart review with phone calls to Veterans and caregivers as needed). Other required HPC services need to be made available as needed through referrals to geographically-accessible VA medical facilities, or through non-VA care mechanisms such as sharing agreements, national or local contracts and individual authorizations to the extent the Veteran is eligible.

17. ELDERLY INPATIENTS

a. Hospitalization of an older adult is far more likely to lead to one or more unintended and undesirable consequences than it might in a younger individual because of the lowered threshold for a stressor to cause injury in a person of advanced age. Hospital-based stressors for elderly patients in hospitals include shiny and slippery floors, bedrails, electrical cords and flexible tubes, unfamiliar locations and floor plans, sleep disrupted by lights and sounds, drug-resistant pathogens, unfamiliar medications and foods, unfamiliar people and schedules—as well as the condition necessitating admission. The consequences of these stressors in older adults often lead to falls with and without injury, disorientation, deconditioning, nosocomial infection, adverse drug reactions, delirium, and dehydration. In turn, these each, separately or in combinations, lead to increased morbidity and mortality, increased lengths of stay, increased costs of care, increased discharges to nursing home, and increased loss of cognitive and physical function.

b. Acute Care for the Elderly (ACE) was originally described (see paragraph [40.n.](#)) as a distinct part of a medicine ward that was for frail, aged inpatients at elevated risk for decline, disorientation, delirium, and extended length of stay in the inpatient environment. A recently-published randomized control trial (see paragraph [40.d.](#)) has affirmed the benefit of the approach.

(1) An ACE Unit is staffed by an interdisciplinary team collaborating with the admitting team. Patients have been identified either upon admission or following inpatient geriatric consultation on the basis of their elevated risk for the undesirable outcomes listed above. The ACE nurses are particularly attuned to minimizing the environmental stressors.

(2) In VA there are relatively few ACE units, so GEC recommends that all sites with inpatient services offer inpatient geriatric consultation (see paragraph [13.d.](#)) to inpatient services, to provide proactive assessments of frail elderly leading to recommendations for reducing the likelihood for experiencing unintended and unwanted outcomes during their hospitalization, before untoward incidents trigger more detailed efforts. This is sometimes referred to as Virtual ACE because there is no discrete ward with environmental modifications and specially trained staff, but rather recommendations to and education of ward staff on each particular elderly inpatient's specific needs.

c. Nurses Improving Care for Health system Elders (NICHE) is a program for fostering transformation to patient-centered care for older patients within healthcare environments. Developed and led by the New York University College of Nursing with the support of several philanthropic organizations (see paragraph [40.f.](#)), NICHE is based on the Geriatric Resource Nurse (GRN) model, an educational and clinical intervention preparing staff nurses, trained by geriatric advanced practice nurses, to serve as the clinical resource on geriatric issues for other nurses on the unit. The focus of NICHE is prevention and management of pain, pressure ulcers, adverse medication events, delirium, urinary incontinence, and falls through the provision of materials and services that support implementation. The approach had been adopted in over 300 hospitals in the United States by 2010; as of 2015, six VA medical centers were identified with NICHE.

d. Discharge planning from an acute care stay needs to address the same considerations as described in paragraph 15.b.(4) and paragraph [27](#).

18. DEMENTIA PROGRAMS

a. Dementia is a symptom complex characterized by intellectual deterioration (including disturbances in memory as well as language, spatial abilities, impulse control, judgment, or other areas of cognitive ability) severe enough to interfere with social or occupational functioning. Dementia of the Alzheimer's type (DAT) is the most common form of dementia.

b. VHA's goal for Veterans with dementia is continuous quality improvement of comprehensive, coordinated care.

c. VISN and VA Medical Center (VAMC) Dementia Committees. The VHA Deputy Under Secretary for Health for Operations and Management has requested that all VISNs establish VISN and VA Medical Center Dementia Committees (Deputy Under Secretary for Health for Operations and Management Memorandum to Network Directors, "Request to Establish VISN and VAMC Dementia Committees," dated December 3, 2008).

(1) VISN Dementia Committee. Each VISN should establish a VISN Dementia Committee with representation from each VISN facility.

(2) VA medical facility Dementia Committee. Each VISN facility should also establish a VA medical facility Dementia Committee composed of facility level experts.

(3) These committees will provide local leadership concerning dementia care and will provide a link to the VHA Dementia Steering Committee in VA Central Office (VACO). The VISN and VA medical facility Dementia Committees will also coordinate local efforts to implement recommendations from the September 2008 Report of the VHA Dementia Steering Committee. A copy of the VHA Dementia Steering Committee's September 2008 Report is available to VA staff at http://vaww.va.gov/geriatrics/DTC/VHA_Dementia_Steering_Committee_Report_September_2008.pdf. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(4) VISNs should forward to VACO GEC the names of their selected VISN and VA medical facility Dementia Committee Chairpersons and notify VACO GEC of changes that occur.

(5) VISNs and facilities are encouraged to consider carefully the VHA Dementia Steering Committee's recommendations and to develop appropriate local implementation plans.

d. VISNs are strongly encouraged to have at least one site per VISN with a Dementia Specialist (neurologist, geriatrician, psychiatrist, or neuropsychologist with specialized training or experience in dementia diagnosis and treatment; or a

multidisciplinary Dementia/Memory Disorders Clinic) available to other facilities in the VISN directly or through use of telemedicine, so that each VA facility provides or has access to a Dementia Specialist for consultation with Primary Care providers under the following conditions: atypical or complex presentation; rapidly progressive symptoms; Veteran less than 60 years of age; significant behavioral or depressive symptoms; or an accompanying movement disorder.

e. VISN and VA medical center leaders should ensure coordination of care for Veterans with dementia.

(1) VA medical center leaders should determine the best model (e.g., generic or specialized) and location (e.g., PACT clinic, GeriPACT clinic, outpatient GEM, mental health clinic, dementia Geriatric Problem-Focused clinic) for case management and care coordination of Veterans with dementia at their facility.

(2) VISN leaders should allocate sufficient funds to VA facilities to ensure that Veterans with dementia have their care coordinated through Dementia Case Managers, Care Coordinators, Case Management Teams, or Care Coordination/Home Telehealth (CCHT) Teams.

(3) Coordination of care for Veterans with dementia should be integrated into the Patient-Aligned Care Team (PACT) model implemented at each facility.

f. Care for Veterans with dementia is decentralized throughout the network of U.S. VA medical facilities.

(1) Care for eligible Veterans with dementia is provided through the full range of VA health care services, including but not limited to Geriatrics and Extended Care Services.

(a) There are no separate VA eligibility criteria for dementia care. The standard eligibility criteria apply.

(b) Eligible Veterans with dementia can participate in the full range of GEC services and programs including HBPC, HM/HHA, ADHC, respite, PACT, GeriPACT, inpatient hospital, CLC, or hospice/palliative care.

(c) Caregiver support (see paragraph [29](#), below) is an essential part of all of these services. VA clinical staff conducts caregiver assessments, identifying caregiving resources and needs of the Veteran with dementia. This includes the caregiver's educational and emotional needs, problem solving skills, and access to VA and community resources.

(2) In addition to general care for Veterans with dementia in VA outpatient and inpatient programs and settings, some VA facilities have developed specialized dementia care programs. Examples of these specialized services provided at some VA facilities include:

(a) Dementia Clinic. These Geriatric Problem-Focused Clinics (see paragraph [13.c.](#)) provide specialized outpatient services for assessment and management of Veterans with Alzheimer's or other forms of dementia during various disease stages.

1. Dementia Clinics may provide new evaluation and ongoing care as well as follow-up after hospitalization. Dementia Clinics may focus on diagnosis or primary care for Veterans with dementia or may provide a broader spectrum of specialized care from diagnosis to behavioral and medical management of Veterans with dementia on an ambulatory care basis.

2. Veterans with dementia may require unique behavioral, psychosocial, and medical care. The growing number of aging Veterans affected by dementing illness predicted to present to VA with clinical needs in the coming decades, exceeding 226,000 in 2015 and projected to reach 335,000 in 2033, strongly suggests that every VA medical facility and large CBOC should have a dementia clinic available.

3. Where the service is unavailable, the clinical guidance sought when referring a Veteran to this program can instead be obtained by requesting a geriatric consultation (see [13.d.](#), above), or referring to GEM (see paragraph [13.a.](#)), or to GeriPACT (see paragraph [13.b.](#)).

(b) Dementia Unit. These units, generally in a VA CLC, provide specialized inpatient services for Veterans with Alzheimer's or other forms of dementia during various disease stages. The decision to create a segregated VA Dementia Unit is a local VA medical facility decision based on local needs, resources, and staff competencies.

1. Diagnostic Unit - focuses primarily on differential diagnosis of dementia, plan of intervention, short-term behavioral stabilization, and discharge placement. Length of stay is up to 30 days.

2. Behavioral Unit - focuses on treatment of significant behavioral as well as physical problems for Veterans with dementia in addition to discharge placement. Length of stay is typically 30 to 90 days. When this service is provided in a VA CLC, Treating Specialty 69 for Short-stay Dementia Care is used (see VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number).

3. Long-term Care Dementia Unit – Although dementia-specific care may be delivered in any long-term care environment where the resident's safety is protected, the environment is appropriately stimulating, and staff competencies are evident, a health care system may choose to develop and staff a dementia-specific unit. Long-term Care Dementia Units focus primarily on comfort and supportive care of Veterans in the later stages of their dementing illness. This service may be provided on a specialty unit within a VA Community Living Center (Treating Specialty 42; see VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of

Veterans Affairs Community Living Centers, or subsequent policy issued, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

(3) A specialized Dementia Clinic or Dementia Unit must have a written mission statement identifying program goals and a philosophy of care pertaining to individuals with dementia. In addition, at least 50 percent of the individuals admitted to the clinic or unit must have a diagnosis (or probable diagnosis) of dementia, with the remaining being geriatric Veterans who may have other types of primary psychiatric diagnoses in addition to some degree of cognitive impairment and who would most likely benefit from the clinic or unit's specialized focus.

(4) Both the inpatient and outpatient components of specialized dementia services involve an interdisciplinary care approach.

(5) Inpatient and outpatient dementia services are coordinated by VA health providers within the broad continuum of health care, in order to maximize continuity of care for Veterans with Alzheimer's disease or other dementia.

19. NEW DEVELOPMENTS IN GEC PROGRAMS

The 2009 GEC Strategic Plan's first goal is that GEC provide Veteran-centric services. This requires responsiveness to each Veteran's clinical needs and personal preferences, including the preferred site and components of care. The GEC programs described in paragraphs 1-15 above offer a wide range of options effecting Veteran-centric care delivery. But because different cohorts of Veterans seeking GEC services will change and health professions themselves will evolve, it is important for GEC programs at all points of care to be flexible and responsive to changing needs and resources. Such flexibility is an essential strength of GEC programs and should be encouraged and supported as long as the following fundamental principles are reflected in the innovations introduced:

- a. Veteran-centricity;
- b. Evidence-based;
- c. Interdisciplinary team-based;
- d. Promoting the greatest Veteran independence that is desired and safe;
- e. Devoted to reversing, halting or slowing functional decline;
- f. Supporting a seamless continuum of care;
- g. Integrated with family/caregiver- and community-provided services;
- h. Equivalent or superior outcomes for equivalent or diminished unit cost; and

i. Monitored for processes and outcomes to drive continuous improvement and systems redesign.

20. GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS

a. Geriatric Research, Education, and Clinical Centers (GRECCs) are centers of geriatrics excellence in research, education, and clinical innovation authorized by Congress in 1980 to (1) improve and expand the capability of Veterans Administration health-care facilities to respond with the most effective and appropriate services possible to the medical, psychological and social needs of the increasing number of older veterans, and (2) advance scientific knowledge regarding such needs and the methods of meeting them by facilitating higher quality geriatric care for eligible older veterans through geriatric and gerontological research, the training of health personnel in the provision of health care to older individuals, and the development of improved models of clinical services for eligible older veterans (Public Law 96-330). By focusing on both geriatrics and gerontology, the GRECCs have been and continue to be models of interdisciplinary team function.

b. By law, each GRECC has a tripartite mission:

(1) **The Research Mission.** The research mission consists of funded, peer-reviewed investigations within one or more circumscribed focus areas in the basic biomedical, applied clinical, and health services/rehabilitative issues surrounding aging, the aged, and their health care and functional needs;

(2) **The Education Mission.** The education mission is focused on health provider training in the care of the elderly, at graduate and postgraduate levels; among VHA staff and trainees and community providers, and in partnership with academic affiliates; within local as well as regional and national spheres; and covering a broad range of healthcare disciplines; and

(3) **The Clinical Innovation Mission.** The clinical innovation mission is intended to advance geriatric practice through the development and evaluation of new approaches—which when demonstrated as effective, are to become integrated into the fabric of, and supported by, the parent health care system; and then, ideally, exported elsewhere within VA and beyond. It is unacceptable for a GRECC to serve as the clinical geriatrics and extended care program of its host site. Staffing status or management decisions bringing that about, to the detriment or fulfillment of the GRECC's statutory tripartite mission, could result in the loss of the designation of the site as a GRECC, and loss of the FTE granted with that original designation.

c. GRECC programs' purpose, authority, background, scope and goals, program standards, staffing, and quality management are covered by VHA Handbook 1140.08, Geriatric Research Education, and Clinical Centers (GRECCs), or subsequent policy issue, available at

http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number.

d. Growing concerns over VHA's workforce adequacy (see paragraph 9) are raising the importance and visibility of the GRECCs' education mission and activities. The drive to enhance the geriatrics skills of primary care providers and their support staff working in PACTs (see paragraph 32, below) is a second, complementary driver expanding GRECC educational offerings. VHA relies on GRECCs to lead efforts enhancing non-specialists' skills and knowledge in care of the frail elderly.

e. Most GRECCs are located in a single VA medical facility although several involve two campuses within the same VISN. Each GRECC serves as a local, regional, and national resource in geriatric education, clinical innovation, and research leadership.

(1) There can be more than one GRECC per VISN, where VISN support and local VA and affiliate strengths are and can be reasonably projected to remain appropriate in quality and characteristics.

(2) The relationship between each GRECC and its host VISN, at a minimum, needs to be the subject of an annual, formal collaborative process clarifying each party's expectations of the forthcoming fiscal year. The final agreement is a written Memorandum of Understanding signed by Directors of the host VISN, host facility and GRECC; and shared with the Deputy Under Secretary for Health for Operations and Management (10N) and the Office of Geriatrics and Extended Care Policy and Services (10P4G).

f. The 2009 GEC Strategic Plan recommended that the number of GRECCs be increased to the Congressionally-authorized level of 25 in accordance with Public Law 99-166. From time to time, VHA makes resources available for new GRECC start-ups. The last such opportunity arose in 2013-2014. VISNs may initiate GRECCs without such funding if the envisioned program complies with the "Requirements for a New GRECC" listed in VHA Handbook 1140.08. A VISN contemplating establishment of a new GRECC needs to confer with the Office of Geriatrics and Extended Care Policy and Services. A GRECC can be recognized only by the Under Secretary for Health upon the recommendation of the VA Geriatrics and Gerontology Advisory Committee, a Federal Advisory Committee.

21. EMERGENCY AND DISASTER PREPAREDNESS

a. A frail or dependent Veteran forced by a personal or regional disaster into a situation of unaccustomed self-reliance until more definitive, longer-term support arrives is at far greater risk for serious, even mortal danger than more robust counterparts. Emergencies and disasters may be widespread and natural (e.g., earthquakes, floods, fires, tornadoes, snowstorms, extremes of hot or cold weather, hurricane); widespread and man-made (e.g., poisoned food or water, accidental release of airborne toxin, terrorism); or limited in extent but no less disastrous to those affected (e.g., a serious mishap or an accident en route to an appointment at the VA medical facility, or incapacitation or loss of a caregiver).

b. By their nature, emergencies and disasters are unpredictable in timing and impact. However their negative effects can be reduced through thoughtful advance planning. Emergency preparedness is a growing priority across the United States. Federal, state, and local government agencies are required to articulate and rehearse emergency responses. Many businesses, schools, and community service organizations do as well.

c. VA's mission includes the mandate to serve as a medical backup to the military health care system during and immediately following a period of war or in a national emergency. Every VISN, VA medical facility, CLC, and SC is required to have a current emergency/disaster plan specifying the role it plays to ensure the safety of employees and Veterans on-site at the time of the emergency; and to provide aid to non-VA businesses and citizens in the vicinity. VA staff and trainees need to receive periodic instruction on their roles and responsibilities in the event of an emergency or disaster.

(1) Plans typically include evacuation protocols; emergency leadership structures; ensuring onsite presence of oxygen, potable water, and power for medical equipment; ensuring availability of wheelchairs and food; establishing contracts with local emergency medical services and technicians; and provision of temporary housing for Veterans, staff and civilians.

(2) Individual VA programs that are responsible for dependent patients must specify the roles they will play on behalf of their patients in the event of an emergency or disaster.

(a) Each HBPC, MFH, CLC, and ADHC program is required to specify its emergency plan in its local handbook.

(b) Community nursing homes, C-ADHC, Community Residential Care facilities, and Medical Foster Homes must have emergency plans and procedures in effect.

(c) Geriatric Primary Care/GeriPACT, HBPC, HMMHA and Care Coordination/Home Telehealth programs make feasible the continued residence at home of dependent Veterans. The local policies for these programs need to specify the role that VA will play on behalf of these patients in the event of an emergency or disaster. If the role played is covered by the overall VA medical facility policy, this needs to be specified in the program's specific policy memorandum.

(3) Policies described in paragraph 21.c.(2) above needs to include guidance regarding emergency-necessitated services and devices such as back up oxygen access and back up electricity supply for Veterans dependent on ventilator, suction machine, oxygen concentrator, etc.

d. Frail older Veterans and their caregivers should be counseled on preparing for both natural and personal emergencies as part of their general preventive health plan, due to their particular susceptibility to perturbations affecting their physical status and their support systems (see paragraph 11). These preparations should include:

(1) Discussions leading to the proactive identification of evacuation routes and places around which families and patient/caregiver dyads can expect to congregate post-disaster;

(2) Consideration for family pets and livestock; and

(3) The assembly of one or more emergency kits (e.g., one for each vehicle and one for the home) that will allow a Veteran to remain safe until local community emergency measures or other outside help can be mobilized. The contents of an emergency kit will vary according to individual needs and preferences but at a minimum, all emergency kits should include items such as:

(a) Emergency lighting, such as a waterproof flashlight with fresh batteries;

(b) Whistle, chemical light stick, mirror, reflector, or other items to alert rescuers;

(c) Fresh water and high-energy snacks;

(d) Identification (including health insurance/Medicare card) and a small amount of cash;

(e) Contact information for health professionals, caregivers, family members;

(f) A fresh 3-day supply of all medications and a list of medical conditions;

(g) Personal hygiene items, including soap and toothbrush, a change of clothes, and incontinence supplies if needed; and

(h) Photos that may become useful for reorienting a confused and frightened individual.

22. RURAL ACCESS TO GEC SERVICES

When younger residents of a rural area relocate to urban centers for improved vocational and educational opportunities, the elderly proportion of that rural Veteran population will rise. These older rural-dwelling Veterans experience substantial travel times to reach VA medical facilities, increased reliance on VA due to limited access to non-VA health care resources, and greater susceptibility to weather-related transportation challenges. Providing access to the widest available range of VA services to Veterans residing in rural areas, particularly the elderly or disabled, is a major VA priority. GEC plays a lead role in developing innovative extended care programs supporting Veterans in rural areas, joining primary care, surgery/specialty care, mental health and telehealth programs as a key partner in reaching out to elderly Veterans and their families and other caregivers in remote areas.

a. VISNs and VA medical facilities have led the needed expansion through CBOCs, which should receive serious consideration as means for expanding access even further

through HBPC (see paragraph 14.b.(2), above) as well the HBPC-related program Medical Foster Home (see paragraph [14.g.](#)).

b. CBOCs also represent a means for providing Geriatric Consultation (see paragraph [13.a.\(4\)](#)), Geriatric Evaluation (see paragraph [13.c.](#)), and GeriPACT (see paragraph [13.b.\(3\)](#)) even if the service doesn't justify a FTE provider. Consideration should be given to having the provider and their team service a "circuit" through which they provide their support to different sites of care on different days. This same approach has been piloted successfully to expand access to Adult Day Health Care (see paragraphs [14.a.\(1\)](#) and [14.c.\(2\)](#)) in rural areas.

c. Telehealth to a Veteran's home (see paragraph 14.g.) offers a range of options for chronic disease management without the need for travel, and should be explored to enhance access in rural areas. Telehealth and videoconference capabilities at SC should also be employed to enhance access to specialty care, whether through:

(1) Secure virtual contact between patients at home and specialists;

(2) Patients at an SC and specialists at other VA sites; or

(3) Consultative support of SC-based providers by specialists at other VA medical facilities.

d. Rural areas are less likely than more populated regions to offer support services for which Veterans may be eligible, such as HM/HHA, Respite or [ADHC](#). Veteran Directed Home & Community Based services (see paragraph [15.d.\(1\)](#)), empowers Veterans and their families to secure these and other services through several different mechanisms, including payment of suitably-trained neighbors, families, or friends.

e. VA Social Work and Community Health Nursing staff must become aware of, and then keep current on changes in, the range of support options on which they may draw on behalf of their rural, elderly or disabled Veteran clients. The resources of the Veterans Community Partnerships (see paragraph [31](#)), Hospice-Veterans Partnerships (see paragraph [16.c.\(4\)](#)), Veterans Service Organizations and VA Voluntary Services can serve as invaluable partners in securing not only health services but also in identifying and accessing transportation and other necessary supports.

23. NATIVE AMERICAN VETERANS OF ADVANCED AGE

a. Native American males in the 20th and 21st centuries are more likely than males of the non-Native population to have served in the U.S. Armed Forces, and the same factors that have brought about the increase in the elderly Veteran population as a whole have also led to growth in the elderly Native Veteran population.

b. Most Native Veterans reside in urban settings and can therefore access VA services to the same measure as non-Native counterparts. Yet because of the greater challenges of access to health services in rural settings described in paragraph [22.a.](#) above, VHA has recently expanded its collaborative efforts with the Indian Health

Service (IHS) to enhance access for Veterans in rural areas that abut or include Native American reservation lands. The historically strong focus on early child and maternal health on the part of IHS has expanded in recent years to be responsive to the same demographic trends experienced elsewhere in American society, leading to increased need for geriatrics healthcare and supports in these communities.

c. Regardless of setting, all VA staff dealing with older Native Veterans should be culturally competent in their interactions. The achievement of cultural competency on the part of staff can be facilitated by accessing resources available through either the VA Office of Minority Affairs or the VA Office of Tribal Government Relations.

24. WOMEN VETERANS OF ADVANCED AGE

a. The number of women Veterans using VHA has doubled in the last decade, with the largest cohort in the 45-64 year age group. In 20 years, these women will be between the ages of 65 and 84 and will require expanded healthcare services, including geriatric primary care, specialty care, and extended care services.

(1) As these women become Medicare-eligible, seamless coordination of care across healthcare systems will become increasingly important.

(2) The life expectancy for women is seven years longer than for men and, as such, support for their frequent roles as caregivers for their families must always be a priority.

(3) Almost one-third (29 percent) of all women Veteran patients resided in a rural area in FY10. Therefore, it is essential for VHA to move quickly to explore innovative ways to extend health care access to women Veterans in rural areas.

(4) Many women Veterans have histories of trauma, including approximately one in four who have experienced military sexual trauma (MST). It is critical to ensure that health care personnel have appropriate training to provide gender-sensitive, trauma-informed health care.

b. Where not yet present or configured adequately to meet the unique needs of women Veterans, patient care systems and staff training and education must be enhanced. The best option for individual Veterans must be determined at the local level based on local resources, expertise, and individual patient needs.

(1) The primary care of aging women must be provided in a manner that supports the concept of comprehensive women's health primary care. This concept, as delineated in VHA Handbook 1330.01, Health Care Services for Women Veterans, or subsequent policy issue, available at http://www.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number, requires that acute medical care, chronic disease management, basic mental health care and gender-specific primary care be delivered by a trained, proficient, and interested designated women's health provider. This care may occur in a PACT, women's health PACT, GeriPACT, or other setting.

(2) Coordination of care with specialty services for gender specific needs, such as urinary incontinence and gynecologic cancers, or for conditions that are common in or have special features in older women, such as osteoporosis and cardiovascular disease, is essential.

(3) Mental health conditions and use of mental health services are more common for women across all age groups; yet, women continue to be a minority within the health care system. As such, provision of gender-sensitive mental health care and coordination with geriatric mental health services are particularly important for meeting the health care needs of women Veterans.

(4) Inpatient, outpatient and extended care settings must be designed or modified to ensure patient privacy, comfort, and security regardless of gender. Gender-sensitive changes to facilities, including restroom modifications, the addition of gynecologic examination tables and other adjustments, are necessary if VA medical facilities do not currently meet the needs of the rapidly growing female Veteran population.

(5) Training will need to be developed and deployed to meet the needs of women Veterans of advanced age regardless of care setting

25. VETERANS WITH SPINAL CORD INJURY AND DISORDERS

a. To address the unique aspects of delivering primary care, specialty health care, and rehabilitation services to Veterans with spinal cord injury and disorders (SCI/D), care should be coordinated through a designated VHA Spinal Cord Injury Center. These Centers are part of VHA's SCI/D System of Care, an integrated service delivery network of care based on the longstanding hub and spoke model within specified catchment areas (see VHA Handbook 1176.01, Spinal Cord Injury System and Disorders (SCI/D) System of Care, or subsequent policy issue, available at http://vaww.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_number), and independent of GEC programs. The scope of SCI/D Center services includes: 1) SCI Comprehensive Preventive Annual Health Evaluation (this includes health promotion, prevention, and early identification and treatment of complications related to living with an SCI/D); 2) assessment and treatment of unique SCI/D-related conditions (e.g., neurogenic bladder and recurrent urinary tract infections, neurogenic bowel, pressure ulcers, autonomic dysreflexia, and neurologic decline); 3) orthotics, prosthetics, sensory aides, and assistive technologies; 4) rehabilitation; 5) patient and family education; and 6) psychological, social, and vocational services.

b. The full array of services and settings are available to help coordinate and deliver care to Veterans in long term care settings including admissions to the inpatient unit, outpatient visits, tele-consultation, and/or consultative visits to the CLC (see paragraph 15.b., above) if within a reasonable distance from the SCI/D Center. The full range of services and options for care for Veterans with SCI/D is described in VHA Handbook 1176.01, cited above. There are also many educational opportunities available for providers in CLCs who care for Veterans with SCI/D, including the course "Medical Care of Persons with Spinal Cord Injury" (available on the Talent Management System, with

Continuing Education Unit credit for physicians and nurses). The SCI/D Service intranet site (<http://vaww.sci.va.gov>) has links to many more resources including Clinical Practice Guidelines and Consumer Guides, Handbooks and Directives related to SCI, and links to videos about SCI. **NOTE:** *This is an internal VA Web site that is not available to the public.*

26. VETERANS REQUIRING MECHANICAL VENTILATION

Veterans who require mechanical ventilation (e.g., due to amyotrophic lateral sclerosis) are generally placed in community-based settings that offer this service, under the authority of the Community Nursing Home program (see paragraph [15.d.](#)), or in VA CLCs (see paragraph [15.b.](#)).

27. CARE TRANSITIONS

a. Transitions between venues and programs of care have been consistently identified as common sources of potentially threatening errors and mishaps in the provision of a continuum of health care, including:

- (1) Changed, added, and redundant prescriptions;
- (2) Inadequately explained or poorly understood post-care instructions;
- (3) Failure to plan adequately for transportation, home safety, and durable medical equipment needs;
- (4) Failure to schedule subsequent clinical encounters in a timely manner following discharge;
- (5) Discontinuity in documentation
- (6) Inadequate consideration of caregiver involvement;
- (7) Coordination with community services; and
- (8) Discontinuity in communication of patient goals, preferences, and plans of care.

b. With increasing age and disability, Veterans utilize a broader range of clinical programs at an increasing rate—meaning that no other group experiences as many care transitions. Each of the undesirable occurrences in paragraphs 27.a. (1)-(8) above is potentially more harmful and more likely as clinical complexity increases. Furthermore, over 62 percent of Veteran patients age 65 and over also receive Medicare-covered services outside of VA and such transitions from and among such services are less likely to be fully and accurately recorded in the VA healthcare record.

c. VHA supports a seamless continuum of care, encompassing both the sending and the receiving aspects of the transfer, for older and/or disabled Veterans. VA medical facilities are responsible for ensuring care transitions are an integral part of

daily clinical operations and system redesign efforts. VA medical facilities need to allocate adequate FTE resources to care managers for transitional care activities, to coordinate Veterans' clinical needs and community supports as they transition among different care settings. This is needed for PACT and for other primary care, non-institutional venues such as GeriPACT and HBPC.

d. Successful transitional care is dependent upon the development of and access to a comprehensive plan of care throughout the transition process; and the availability of well-trained health care practitioners in chronic care having current information about the Veteran's goals, preferences, and clinical status. As detailed in paragraph 15b(4) above, it includes logistical arrangements, Veteran and caregiver/family education, and coordination among health professionals involved in the transition. Care Transitions must include at a minimum:

- (1) Medication reconciliation;
- (2) Veteran/caregiver education;
- (3) Coordination with community services and referrals;
- (4) Communication with non-VA providers involved in the transition;
- (5) Assessment of need for referral to other VHA home and community based services;
- (6) Assessment of need for referral to non-VHA home and community based services;
- (7) Ensuring that timely follow up appointments are made and kept;
- (8) Assistance with procurement of durable medical equipment; and
- (9) Assistance with transportation needs.

28. CARE MANAGEMENT

a. Definitions:

(1) **Care Management.** Care management (termed "care coordination" with increasing frequency) is the process by which components of a patient's comprehensive health care plan, including the patient's ability to perform self-care are assessed, analyzed, and optimized for the patient's desired health and wellbeing. Care management is the oversight and management of a comprehensive health care plan for an individual patient or a cohort of patients. It is a systems approach to the implementation and facilitation of longitudinal care coordination, focusing on linking Veterans and their families with needed services, resources, and opportunities for wellness. Care management encompasses a broad spectrum of care across VA and non-VA continuums, identifying strategies to provide integrated services that enhance

collaboration with interdisciplinary healthcare team members and promote Veteran-centered care. The service is generally provided by a licensed health care professional, predominantly registered nurses or social workers, working within an interdisciplinary team. The specific activities of such care managers include assessing the risks and needs of each Veteran; working with the Veteran, his or her family, and the interdisciplinary care team to prepare a care plan; teaching Veterans and their families about their diseases and medications; coaching Veterans and families on how to respond to worsening symptoms in order to avoid emergency department visits and hospital admissions; tracking Veterans' status over time; and revising care plans as needed. Care management is an essential responsibility of PACT and GeriPACT.

(2) **Case Management.** Case management is a specialized and highly skilled service provided to individual Veterans and their families requiring intensive support and monitoring due to complex medical or psychosocial factors. Case management interventions are necessary when the Veteran, family and/or caregiver require a more intense level of care coordination beyond the level offered by the PACT team. Case management requires frequent assessment, planning, advocacy, support, coordination of multiple services, and evaluation to meet the Veteran's complex needs. It may be short term or long term, based on clinical needs, with interventions occurring at the individual Veteran, family, and system levels. Case management is intended to optimize resource utilization, promoting quality and Veteran Centered Care while producing cost effective outcomes. Case management is generally provided by a licensed health care professional, predominantly registered nurses or social workers, working with an interdisciplinary team.

b. Each VA medical facility needs to provide care/case management services for Veterans requiring this type of care. Care/case management is generally provided by MSWs and RNs assigned to particular services (e.g., GEC, Mental Health) or programs (e.g., Acute Care, ICU). Responsibilities may include acting as the lead care/case manager for emerging medical and psychosocial problems and providing care coordination.

(1) **Intensive Acute Case Management.** Intensive acute case management is the most intensive level of case management and is geared towards those Veterans with the highest levels of acuity.

(2) **Chronic Illness Case Management.** Chronic illness case management targets the high-risk and most complex Veteran with chronic illness who is often homebound with limited financial resources and support structures.

(3) **Specialty Populations for Clinical Case Management.** Specialty populations consist of those Veterans who are considered to be at high risk for decline or increase of resource utilization, have complex care needs, or require significant coordination of care. Such Veterans should be assessed for care management services prior to discharge from inpatient units and within primary and specialty care clinics; and include, but are not restricted to, Veterans participating in one or more of the following programs or services:

(a) Home Based Primary Care (HBPC);

(b) GeriPACT;

(c) Dementia Care;

(d) Transitional Care;

(e) Telehealth; or

(f) Medical Foster Home (MFH)

c. The role of the RN Care/Case Manager is to

(1) Ensure medical needs are addressed;

(2) Facilitate seamless transitions;

(3) Identify cost-effective resources;

(4) Provide intensive care/case management for a sub-group of at-risk Veterans;

(5) Link Veterans with resources across the continuum;

(6) Address and assist effective management of preventive/chronic disease care needs; and

(7) Provide caregiver support and education.

d. The role of the SW Care/Case Manager is to:

(1) Address bio-psychosocial status and social support system;

(2) Eliminate barriers to healthcare interventions;

(3) Follow the Veteran through continuum of health care;

(4) Coordinate care across specialty areas and care setting;

(5) Provide Veteran/caregiver and family education and support; and

(6) Coordinate resources to assure comprehensiveness and avoid duplication.

29. CAREGIVER SUPPORT

a. The high prevalence of dependency observed among Veterans of advanced age, Veterans with severe injury or illness, and those involved in VA GEC programs makes essential the integration of Veterans' services with programs and services targeting caregivers as well. This is important to ensure each caregiver's contribution as a

partner in the provision of VA-directed care, and to support the well-being of Caregivers, without whose efforts care becomes more complex, more costly, and results in poorer outcomes.

b. Each VA medical center has a Caregiver Support Coordinator (CSC) who may be a social worker, nurse, or psychologist, and who serves as the medical center's "expert" on caregiving and caregiver support.

(1) Each CSC is the lead within the VA medical center for the caregiver support program titled "Program of Comprehensive Assistance for Family Caregivers," established by the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163); and is responsible for coordinating the application process, the program and also working closely with Veterans and caregivers applying for other caregiver support services.

(a) "Program of Comprehensive Assistance for Family Caregivers" establishes a program of support for designated and approved family caregivers of eligible Veterans seriously injured in the line of duty on or after September 11, 2001 who are in need of personal care services.

1. Services limited to family caregivers of eligible Veterans under the Program of Comprehensive Assistance for Family Caregivers are provided to the two groups of caregivers described in paragraphs 29b(1)(a)a. and b. below

a. Primary Family Caregivers are eligible for the broadest array of caregiver services. In order to be approved as a Primary Family Caregiver, each applicant is required to participate in a core caregiver training program and receive any needed Veteran-specific training. Each Primary Family Caregiver is paid a stipend based on their eligible Veteran's level of dependence and amount of caregiver support needed. Health care coverage is available through CHAMPVA if the Primary Family Caregiver is not entitled to care or services under a health-plan contract. Counseling services are available through VA to treat Primary Family Caregivers independent of and not related to the eligible Veteran's condition or the provision of care for the eligible Veteran. Primary Family Caregivers may receive travel, lodging, and per-diem expenses, as well as respite care for the eligible Veteran while receiving initial training. Primary Family Caregivers may be eligible for expenses of travel (including lodging and subsistence) for travel to and from and during the duration of the eligible Veteran's VA appointments.

b. "Secondary Family Caregivers" serve as backups for the Primary Family Caregiver. An eligible Veteran may have up to two Secondary Family Caregivers in addition to the Primary Family Caregiver. Secondary Family Caregivers also receive core caregiver training and specialized Veteran-specific training, and may be eligible for travel, lodging, and per-diem expenses, as well as respite care for the eligible Veteran while receiving initial training. Secondary Family Caregivers may be eligible for expenses of travel (including lodging and subsistence) for travel to and from and during the duration of the eligible Veteran's VA appointments.

2. Application for the “Program of Comprehensive Assistance for Family Caregivers” requires the submission of the 10-10CG application form. The clinical team completes an assessment of the Veteran’s and caregiver applicant’s eligibility for the program. The caregiver must complete a core training that provides instruction on: medication management; vital signs and pain control; infection control; nutrition; functional activities; activities of daily living; communication and cognition skills; behavior management skills; skin care; and caregiver self-care. After the training is completed, an in-home assessment is conducted by a VA clinician or a clinical team. This home assessment includes a brief assessment of the eligible Veteran’s well-being and ensures that the caregiver has all of the resources, equipment, and support that he or she requires in order to adequately care for the eligible Veteran. Once enrolled in the program, home visits continue to be completed every 90 days, unless otherwise clinically indicated with the same goals of providing education and support to the caregiver.

(b) “Program of General Caregiver Support Services.” General Caregivers are caregivers who provide personal care services for Veterans who do not qualify for the “Program of Comprehensive Assistance for Family Caregivers.” The CSC works with primary care and specialty PACTs within the VA medical center to assist teams in providing services and support for caregivers of Veterans of all eras. The services that work to support caregivers of Veterans of all eras include:

1. Education and training, including in-person education, telehealth training, interactive websites, teaching techniques, strategies, and skills for caring, pre-discharge care instruction and specialized caregiver programs in multiple severe traumas such as Traumatic Brain Injury (TBI), Spinal Cord Injury/Disorders, and Blind Rehabilitation;

2. Caregiver support groups offered in a face to face setting or via the telephone, provide emotional and peer support, and information on family counseling, spiritual and pastoral care, and family leisure and recreational opportunities offered by non-VA entities;

3. Transportation assistance for some Veterans to and from medical appointments;

4. In-home care, such as skilled home health care, homemaker home health aide services, community adult day health care and Home Based Primary Care;

5. Respite care under 38 U.S.C. 1720B for eligible Veterans; and

6. Counseling and other services including individual and group counseling and psychotherapy, marriage and family counseling, and education when necessary in connection with the treatment of a disability for which the Veteran is receiving treatment through VA, i.e., if provision of the benefit would further the objectives of the Veteran’s medical treatment plan. Medication, inpatient mental health treatment and other medical care related to mental health treatment are not included.

30. TRANSPORTATION BARRIERS

a. Transportation to health facilities is frequently a substantial challenge to a frail or elderly Veteran, when cognitive, visual, or financial limitations necessitate dependence on others for travel. The results of this can include:

- (1) Delays in seeking care leading to clinical exacerbations; and
- (2) Disrupted or delayed discharge planning.

b. Each of these represents increased lengths of stay, avoidable excess expense to the health system, and diminished health status for the Veteran. The growing use of telehealth strategies for much of chronic care (see paragraph 14b(1)) has diminished some impact of this factor, but it is unable to eliminate it entirely.

c. Each clinical care site should consider designating a staff member to serve as a transportation coordinator who works with care teams to insure that functionally and cognitively impaired Veterans have timely transportation to and from clinics.

31. COMMUNITY PARTNERSHIPS

a. Development and successful function of Community Partnerships are VA priorities and the Office of Community Engagement (OCE) issues guidance (e.g., http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=803&FType=2) to direct and facilitate the establishment and tracking of such relationships.

b. Facility GEC Community Social Workers and Community Health Nurse Coordinators should take an active role in conducting needs assessments, networking with community providers and development of joint VHA-Community Programs that may include such partners as CMS, Administration on Aging, State and local agencies, and neighborhood or church resources.

c. In compliance with OCE guidelines, VA medical facilities should engage in partnerships, when appropriate, with community agencies such as local Area Agencies on Aging, other aging services, and community health providers such as local hospitals, nursing homes, home care agencies, hospices, and public health clinics.

d. As directed by OCE, these partnerships should be codified in Memorandums of Understanding or Agreements between the community agency and the VA medical facility. VA medical facilities should allocate adequate resources (such as an RN case manager and/or Social Worker) to develop and maintain these partnerships, and MOUs/MOAs facilitating Veteran's care across the spectrum of both VA and non-VA care.

e. Examples of GEC-affiliated Community Partnerships are the Hospice-Veterans Partnerships (see paragraph [16.c. \(4\)](#)) and the Veterans Community Partnerships (VCP) program. VCPs are modeled after the Hospice-Veteran Partnerships, with focus on fostering seamless access to, and transitions among, the full continuum of non-institutional extended care and support services in VA and the community. VCPs are

networks of VA facilities, Veterans, volunteers, caregivers, community service agencies, and other interested parties working in collaboration to:

- (1) Enhance and improve choice and access to quality care;
- (2) Promote seamless transitions along the continuum of care;
- (3) Familiarize community agencies with VHA services, options, and personnel;
- (4) Familiarize VA providers with community services, options, and personnel;
- (5) Support caregivers; and
- (6) Develop and enrich working relationships between VA and the community

32. INTEGRATING GEC AND PRIMARY CARE SERVICES

a. Over 95 percent of Veterans age 65 and above are followed in primary care clinics, which since 2010 are increasingly organized around principles of the American College of Physician's Medical Home model (see paragraph [40.b.](#)). For this reason, integration of GEC services—services that are largely provided to those of advanced age and services that are generally initially called for by primary care providers—with primary care clinics, termed Patient-Aligned Care Teams (PACTs) is crucial both for the successful primary care of older and disabled veterans and for the successful implementation of geriatrics and extended care programs.

b. The PACT approach is aligned with the Chronic Care model described by Bodenheimer et al. (see paragraph [40.e.](#)). The integration of GEC activities with primary care in VA is likewise conveniently described with reference to each of that model's five domains:

(1) **Clinical Decision Support.** The PACT model's fundamental goal is to reduce the redundancies and inconsistencies in care prone to occur when Veterans receive care from more than a single care provider or team. PACT affects this by enhancing the team's ability to provide chronic care management, thereby reducing episodes of fragmented care from clinicians unfamiliar with the Veterans, their preferences, and their health histories.

(a) GEC supports this enhancement of PACT skills and knowledge through education on topics including the identification, evaluation, and management of dementia, incontinence, falls, delirium, frailty, polypharmacy and medication reconciliation (see paragraph [11.e.](#)), advanced care planning, palliative care, depression, insomnia, and other "geriatric syndromes." These efforts are accomplished through consultation, co-management, and in-service education. The GRECCs play a growing role in both providing and supporting such educational efforts.

(b) GEC also supports baseline chronic care management by assisting PACT/Primary Care in continuously improving their performance on the quality

indicators reflecting care of frail elderly, the “Frail Elderly” measures that are derived from the ACOVE (“Assessing Care of Vulnerable Elderly”) series (see [11.d.](#)). This assistance may take one or all three of the forms described in (a) as well as providing a selection of instruments (e.g., clinical reminders) that can serve as guides and reminders to PACT teams.

(2) **Health Systems Design.** The management of frail elderly Veterans requires the combined expertise of all participants in the interdisciplinary team because of the multidimensional nature of the clinical conditions encountered, needs identified, and management strategies required to address both. Yet even with the most effective team care, the clinical requirements of geriatric and disabled Veterans may transcend the PACT’s resources, because the special needs of the frail elderly often require mobilization of home and community-based resources to provide assistance beyond the usual experience of many PACTs.

(a) GEC programs have been fundamentally team-based for over three decades. GEC programs such as CLC, HBPC, GEM, and HPC GRECC are singularly experienced at sharing team-based practices, as are GRECCs that coordinate educational experiences within these programs; and these care environments are proven, enthusiastically well-accepted training environments for building clinical teamwork skills among existing staff and healthcare trainees. That they offer exposure to and immersion in a range of Veteran-centric geriatric care environments (see paragraph 32.b. (2) (b), following) is an added benefit; but they first and foremost provide experiential involvement in effective and experienced team management environments.

(b) One of GEC’s most important contributions to PACT is the communication to PACT of the means and criteria for access to the range of GEC programs. The full range of programs is described in paragraphs 12-16 above; but resources and their availability vary by locale and even over time. GEC needs to have an ongoing means for keeping PACT teams abreast of the resources upon which they may draw on behalf of the Veterans under their care.

(3) **Clinical Information Systems.** GEC and PACT at each care site should collaborate to establish objective criteria (e.g., a “registry”) for referral of geriatric patients, with particularly high-risk characteristics, to GEC without the necessity of a formal consultation process by PACT. The variability in PACT/Geri PACT teamlet compositions and skill sets necessitates customization of registries according to local resources and needs. For example, some health care systems with less confidence in managing complex geriatric patients may initially find it prudent for all Veterans with a documented diagnosis of dementia to be identified to GeriPACT, and therefore select that as their registry criterion. Yet as such a site’s skills and confidence in managing geriatric patients grows the registry criteria likely would merit being limited to those, for example, who have a diagnosis of dementia and have experienced two or more hospital admissions in the prior 12 months.

(4) **Community-based Resources.** As pointed out in paragraph 32.b. (2) above, frail elderly and disabled patients are singularly dependent on resources supporting their function in non-clinical settings, yet in many cases the resources required are not under the purview of VA. Although many can be supported through Medicare or Medicaid, an even wider, yet highly local variety of state-, community-, church-, philanthropic-, and service organization-based programs and services exists in every community to assist dependent persons (see paragraph 31 above). Care managers can best serve Veterans when they have familiarity with the broadest range of such resources available. Because GEC and PACT programs commonly have established contacts and relationships with different blends of these groups, ongoing exchange and constant updating of such information between all PACT and GeriPACT care managers is essential for optimal care.

(5) **Self-management.** The Chronic Care model relies on involvement of patients and their taking responsibility for their own health. With reference to a frail elderly population, prevalent cognitive decline and physical dependency often preclude the Veteran's fulfillment of this expectation in the absence of substantial involvement and support of an informed caregiver. PACT and GEC in conjunction with Social Work at each site of care should collaborate to develop and offer programs to support caregivers that are adaptable to different ages, patient needs, and caregiver expectations; and that includes education about chronic disease management, frailty, dementia care, palliative/end of life care and the avoidance, identification, and management of caregiver burnout. Critical to the last is caregiver awareness (e.g., through resources such as <http://www.va.gov/geriatrics/Guide/LongTermCare/index.asp>) of Respite and respite-related GEC programs such as HBPC (see paragraph 14.b.), H/HHA (see paragraph 14.d.), and Veteran-Directed Home- and Community-Based Care.

33. INTEGRATING GEC SERVICES AND REHABILITATION PROGRAMS

a. Because the fundamental goal of geriatric care is the optimization of function, GEC services are highly dependent on the expertise of providers and therapists in Physical Medicine and Rehabilitation (also termed "PM&R" or "Rehab") Services. Because a substantial proportion of the Veteran population served by Rehab is affected by conditions associated with advanced age, such as stroke, amputation, disorders of gait and balance, and hearing and vision loss, GEC is a frequent contributor to the development and execution of rehabilitation plans of care.

b. Facility GEC programs need to be closely integrated with Rehabilitation Programs, with both groups participating on each other's interdisciplinary teams, contributing to patient assessment and management, promoting Veteran centered care and cultural transformation in extended care settings, optimizing Veteran function, and maintaining Veterans at their maximum potential.

(1) Rehab staff vital to GEC programs include physiatrists, physical therapists, occupational therapists, kinesiotherapists, audiologists, speech/language pathologists, recreation therapists, Blind Rehabilitation Specialists, Blind Rehabilitation Outpatient Specialists, and clinicians with expertise in managing traumatic brain injury patients.

(2) GEC needs to work collaboratively with Rehab to qualify and maintain accreditation from the Committee for the Accreditation of Rehabilitation Facilities (CARF) for in-patient extended care settings devoted to rehabilitation outcomes, such as some CLCs and inpatient GEMs.

(3) GEC needs to collaborate with Rehab to build and maintain the restorative mission within all CLCs to facilitate CLC resident mobility, enhance function, and promote timely discharge to settings of optimal independence.

(a) CLC nursing staff and care partners need to obtain and maintain competencies in restorative care in collaboration with Rehabilitation experts.

(b) Discharge planning will be enhanced as needed by rehabilitation-provided home safety and driving assessments.

(4) GEC will rely on Rehab (and, unless therapists are organizationally aligned with GEC programs, for staff support for these functions) to contribute expertise to HBPC teams, facilitating and maintaining patient mobility, enhancing and sustaining function, and optimizing safety of the home environment.

(a) Home safety will be part of every HBPC assessment.

(b) Appropriate restorative techniques need to be taught by Rehab personnel to nursing staff and caregivers as appropriate.

(5) GEC will draw on Rehab (including for staff support, unless therapists are locally already organizationally aligned with GEC programs) as appropriate for Veterans in Geriatric Primary Care and Outpatient GEM during assessment and the development and implementation of the care plan.

34. INTEGRATING GEC AND MENTAL HEALTH SERVICES

a. There is substantial need for close integration of Mental Health and GEC services, both because of demonstrated, significant need for assessment and treatment of a wide range of mental health conditions in Veterans of advanced age (e.g., depression, anxiety, substance use disorders, PTSD, suicide); and because Veterans with mental illness are at elevated risk for being impacted by complex interacting chronic disorders and disease as they age—and the management of those conditions is often made more complex by mental illness. Consideration should also be given to how an older Veteran's trauma history may intersect with or contribute to other health and mental health concerns.

b. GEC programs need to work closely with Mental Health services, as outlined in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, or subsequent policy issue, available at http://vaww.va.gov/vhapublications/publications.cfm?pub=2&order=asc&orderby=pub_Number. This is particularly true during extended care admissions and during the critical

period of transition to home or to a different level of care; but is also the case in primary care settings such as Geriatric Primary Care and Home-Based Primary Care.

c. Key areas for GEC-MH collaboration (including “warm handoffs”) and integration include:

(1) GEC consultation related to discharge planning and appropriate GEC resources for high-risk Veterans;

(2) Close collaboration related to programming and appropriate referral for Veterans with significant behavioral symptoms, such as agitation, aggression, apathy, disinhibition, impulsivity, inappropriate sexual behavior, resistance to care, repeated vocalizations, sleep-wake cycle changes, or wandering;

(3) Collaboration related to dementia care and education programs;

(4) Integration of full-time MH providers in HBPC and [CLC](#), as specified in the VHA Handbook 1160.01;

(5) Integration of Tele mental health to improve timely access to care, especially for rural Veterans;

(6) Consultation to, and timely admission decisions for, CLC, HBPC, and GeriPACT;

(7) Consultation related to VA-purchased home and community-based care resources (e.g., ADHC, HM/HHA, PSHC);

(8) Consultation and collaboration related to program development of emerging GEC programs including, but not limited to: MFH, Veteran-Directed Home and Community Based Cares and Services, and Hospital in Home;

(9) Collaboration and integration in Hospice and Palliative Care Services, as required in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, and VHA Directive 2008-066, Palliative Care Consult teams (PCCT), October 23, 2008, or subsequent policy issues;

(10) Joint planning and program development related to caregiver support programs and community partnerships; and

(11) Specialized care models are needed for a minority Veterans whose behaviors, due to their neurocognitive and/or mental health conditions, require a higher staff:patient ratio than may be customarily available in CLC and whose chronic physical conditions require medical management beyond what is customarily available in mental health settings. For these Veterans with complex care needs, psychosocial stability and quality of life are ill-served by serial transfers to acute medical services; rather, recovery-oriented, secure, homelike settings with specialized staffing should be available. In many cases, such care may be provided in the CLC when CLC mental health and other interdisciplinary staff have specialized training in evidence-based,

behavioral approaches to managing challenging behaviors (e.g., STAR-VA), and when staffing models take into account specialized care needs. Facility and VISN GEC and MH leadership should collaborate closely in considering optimal models and settings of care for Veterans with complex care needs, and consider piloting and evaluating innovative models in collaboration with VACO GEC and MH program offices.

35. INTEGRATING GEC AND SURGICAL/SPECIALTY CARE PROGRAMS

a. As described in paragraph [17](#) above, the inpatient environment poses substantial risks to those of advanced age. Furthermore, disease-specific plans of care directed by medical subspecialists can often prove problem-prone for aged Veterans, whose conditions are invariably made more complex through other chronic diseases, disabilities, and issues of impaired communication, compliance, and self-care.

b. For these reasons, GEC and Surgical and Specialty Care programs in particular need to work closely together. This is true in ambulatory care settings, and it is particularly important during and in planning for the end of inpatient stays. Key areas for collaboration and integration include:

(1) GEC Consultation related to providing an inpatient environment that will be least likely to lead to disorientation or injury (see [17.b.](#));

(2) Discharge planning that includes assessment of in-home support needs and mindful of appropriate GEC resources for high-risk Veterans;

(3) CLC consultation and timely admission reviews;

(4) Timely review for HBPC and other appropriate referrals;

(5) Consultation related to VA-purchased home care resources (e.g., IV therapy, skilled nursing services, physical and occupational therapy, HHA, respite, etc.);

(6) Hospice and palliative care services and community resources;

(7) Pain management; and

(8) Chronic wound care.

36. INTEGRATING GEC AND DENTAL SERVICES

a. The 20th century witnessed an unprecedented improvement in Americans' dental health across the lifespan. Yet with preservation of teeth into advanced age, the need for daily oral care continues even as self-care, including daily dental hygiene, grows increasingly challenging for many elderly Veterans. Enhanced longevity of the dentition also prolongs risk for experiencing painful and debilitating dental disease into advanced age, when the considerable expense of rehabilitative dental care—never a benefit of Medicare, and a VA benefit for which most Veterans are not eligible--may no longer be borne by employment-related dental insurance and out of reach by those on a fixed

income. Finally, provision of dental care to those with multiple chronic diseases must take into account potential complications arising from medications and more fragile physiological states.

b. For these reasons, GEC programs need to work closely with Dental Services to foster coordination of oral health care, for elderly and frail Veterans eligible to receive those services, in conjunction with the other VA-provided health services.

(1) CLC nursing staff members who have demonstrated proficiency in oral assessment will complete the oral assessment of all newly admitted Veterans as part of the initial completion of the Minimum Data Set. If that competency has not been verified, CLC nursing staff needs to facilitate the completion of the oral assessment by a qualified representative of Dental Service.

(2) GEC programs such as GPC, CLC, GEM, and HBPC are known to be well-accepted and efficacious sites for training in interdisciplinary care. As such, when possible and appropriate, they should extend to interested and motivated dental and dental hygiene trainees and staff opportunities to attend and participate in clinic sessions, team meetings, and home visits.

(3) CLC nursing leadership needs to work with representatives of Dental Service to establish and provide ongoing support for programs of nursing staff-delivered oral hygiene for Veterans in CLCs, as a means for controlling nosocomial pneumonia incidence and optimizing Veteran quality of life.

(4) Each GEC provider and his or her treatment team should strive to be timely in providing assistance to dental personnel who request guidance and/or support in delivering dental care to geriatric or other disabled patients under the care of the provider, including:

(a) Advising on pharmacological interventions prior to delivery of dental care (e.g., modification in anticoagulation regimen, avoiding potential adverse reaction with dental agents, or use of agents to mitigate aversive behaviors during dental treatment);

(b) Advising on transportation options and issues of surrogacy and informed consent; and

(c) Providing periodic in-service education to dental staff on safe wheelchair transfer techniques, behavioral management of and communication with Veterans with cognitive decline, and related challenges encountered by dental teams when treating frail elders.

37. INTEGRATING GEC WITH ACADEMIC AFFILIATIONS

a. For more than three decades, VHA has been a major contributor to the development of geriatric care models and the training of health providers in care of the elderly. Although much of this activity is attributable to the system of 19 GRECCs (see paragraph [20](#), above), many VA medical centers without GRECCs also take advantage of one or more of their interdisciplinary team-based extended care programs to serve as

sites for training students and trainees of the health professions in the care of elderly Veterans. There are five different academic tracks through which GEC and the Office of Academic Affiliations (OAA) collaborate in this important work.

(1) VA maintains affiliations with over a hundred schools of medicine and several hundred schools of nursing. Through these affiliations, trainees undertake supervised, education-focused rotations through a range of VA-based clinical services.

(2) Most sponsoring academic programs affiliated with VA medical centers offer elective or required rotations in CLC for medical and psychiatric house staff (PGY1-3). Some sites, generally those with geriatric medicine fellowships, offer opportunities in palliative and home care as well. With VA supporting over 26,000 such training positions, this is an important opportunity for physician exposure to geriatric care.

(3) Nearly two-thirds of the approximately 200 geriatric fellowship (PGY4) positions in the U.S. undertake some or most of their training in VA settings, and VA supports about one-third of the filled US geriatric fellowship positions in any year. Geriatric fellows generally participate in the full range of GEC programs offered at their sites, including CLC, GEM, Geriatric Primary Care, ADHC, HBPC, and HPC.

(4) Because the requirement to be eligible for Specialty Boards in geriatrics is one year, and for most in medical education this is an inadequate time for preparation in both clinical and academic aspects of the field, since 2000 OAA has offered Advanced Fellowships in Geriatrics through the GRECCs. These involve two years of post-fellowship training with an optional third year. Since 2006, these have also been open to physician specialists from outside of geriatrics, and geriatrics specialists in other health disciplines such as nursing, psychology, occupational therapy, social work, and dentistry. The intent of the Advanced Fellowships is to prepare advanced-level health discipline trainees to undertake independent research and thereby to make them competitive for academic careers.

(5) OAA also annually supports several thousand training positions with stipends for trainees in associated health disciplines such as nursing, nurse practitioner, physician assistant, social work, psychology, rehabilitation therapy, hospital chaplaincy, pharmacy, dietetics, optometry, and podiatry. Approximately 300 of these positions are assigned to GRECCs but the remainder of these positions is the responsibility of the host discipline at each site. GRECC trainees spend much or all of their time assigned to GEC programs; an untracked but substantial number of the positions not affiliated with GRECCs do as well.

38. GEC INFORMATICS, WORKLOAD CAPTURE

There are various VHA electronic databases capturing quality metrics and workload data that are accessible to GEC program managers, some requiring protected health information access.

a. Application to obtain access to protected health information is obtained from facility National Data Systems (NDS), as described on the VHA Service Support Center

(VSSC) Web site at: https://help.vssc.med.va.gov/cgi-bin/VSSCHelpDesk/wonderdesk.cgi?do=faq_view_record&faq=1&view_detail=1&faq_id=4

b. VSSC offers a variety of web reports and Cube (Access and Clinic Administration, Business Operations, Capital & Planning, Clinical Care, Customer Service, Quality & Performance, Resource Management, Special Focus and Workload) Reporting: <http://vssc.med.va.gov/>

c. The Managerial Cost Accounting (MCA) Reports Web site (<https://mcareports.va.gov/>) offers cohort-specific components relevant to GEC, as well as patient- and station-centric reports which include the cost of care. **NOTE:** *This is an internal VA Web site that is not available to the public.*

d. The VHA Office of Analytics and Business Intelligence (OA&IB) (10P2B1) Web site has sections devoted to performance measures, and their reporting may be accessed through their home page: <http://vaww.car.rtp.med.va.gov/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

39. PERFORMANCE AND QUALITY IMPROVEMENT

a. VHA Performance and Quality Improvement activities need to be evidence-based, robust, and transparent.

b. Measures that reflect program structure, care processes, and outcomes need to be tailored to the geriatric and/or disabled population, focusing on:

(1) Quality of life;

(2) The detection and management of geriatric syndromes (e.g. delirium, dementia, falls, incontinence, etc.); and

(3) Functional domains (e.g., role, physical, cognitive, social, etc.).

c. Measures vary according to the care setting and program.

(1) CLCs use the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) generated Quality Indicators and Quality Monitors to monitor improvement; “Advancing Excellence” to reflect sites’ progress in their transformation to Veteran-centered care; and reports from the VSSC, Corporate Data Warehouse (CDW), and Inpatient Evaluation Center (IPEC).

(2) HBPC uses External Peer Review Program (EPRP), selected VSSC reports on workload and patient demographics; and an MCA report to compare patient costs and utilization pre- and post-enrollment in HBPC.

(3) GeriPACT uses selected VSSC reports on workload and patient demographics; MCA reports on patients' costs and utilization, and the PCMM to track panels and patient characteristics, and to employ population management tools.

(4) GEC, in conjunction with OA&BI, has developed several "Effectiveness of Care" Measures, which are compiled through the EPRP chart review system. These measures are derived from the "Assessing Care of Vulnerable Elders" (ACOVE) suite of measures (see paragraph [11.d.](#)), developed by RAND Health researchers specifically for the vulnerable elderly, and identified in VHA's "Effectiveness of Care" Measures as "Frail Elderly" (FE) measures. The "Electronic Technical Manual" link on the OA&BI website is the location of the FE Measure Definitions. The FE Measure Reports may be accessed through the OA&BI website at the "Measure Master" link on the "Performance Measurement Reporting" page.

(5) HPC employs VSSC- and CDW-accessible reports to track inpatient consults and deaths; time between consultation and death; CLC-based hospice care; and conducts surveys of families after a Veteran's death (the Bereaved Family Survey).

d. Performance and Quality Improvement initiatives should also be attentive to national external accrediting bodies' standards appropriate for each program. VA medical centers need to utilize survey results to improve programs and services and to identify, design, and develop new programs.

(1) The Joint Commission's (TJC) Home and Long Term Care accreditation standards have chapters with elements of performance dedicated to performance improvement and patient safety goals. VA medical facilities must familiarize themselves with these particular performance elements to assure organizational compliance and ongoing accreditation with the TJC for their specific geriatric programs.

(2) VA contracts with outside agencies to augment TJC's review of VA CLCs. The purpose of the additional oversight is to identify issues in advance and to take action, provide education, encourage culture transformation, and improve care.

(3) VA medical facilities should consider Veteran/family focus groups to identify gaps in services in urban, rural and highly rural areas; in primary, acute inpatient, and long term care; and in hospice care.

(4) VA medical facilities' GEC Programs staff needs to coordinate with VA medical center and VISN Public Affairs Offices (PAO) as appropriate in periodic administration of Customer Satisfaction Surveys, within guidelines imposed by the Office of Management and Budget.

(5) VA medical centers will develop and clearly instruct Veterans and their families/caregivers concerning avenues/key contacts to address complaints about GEC services or disputes related to services denied.

e. VA-purchased GEC services must be carefully monitored through a range of approaches to ensure appropriate quality of the care. VA medical centers need to

devote adequate FTE, information technology support, government vehicles, space and other resources to support an effective quality oversight program for all VA-paid H&CBC Programs including:

- (1) Community Nursing Home;
- (2) Purchased Skilled Home Care;
- (3) Community Hospice Care;
- (4) Homemaker/Home Health Aide;
- (5) Community ADHC;
- (6) Community Residential Care;
- (7) Veteran Directed Home & Community Based Services (including PACE); and
- (8) State Veterans Home program (a per diem grant program).

f. VA medical centers administering GEC programs need to remain responsive to emerging legislative and regulatory actions dictating changes in tracking and measurement that may arise during the funding, management, and oversight of these programs.

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