GERIATRIC EVALUATION AND MANAGEMENT PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook provides the historical context of, and guidance for, clinical and administrative staff in developing and operating geriatric evaluation and management (GEM) programs.

2. SUMMARY OF MAJOR CHANGES: This is a new Handbook that updates and revises the information in Manual G-2, M-5, Pt. VI, dated 8/25/92, "GEM Program Guide." The Background section has been expanded to include more recent scientific analyses of GEM programs. Operational guidelines have been revised to reflect current VHA nomenclature and organization. Appendices citing locales and personnel of GEMs and other geriatrics resources in VHA have been removed.

3. RELATED PUBLICATIONS: VHA Directive 1140 (to be published).

4. FOLLOW-UP RESPONSIBILITY: The Chief Consultant for Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Handbook. Questions may be addressed to 202-273-8540.

5. RECISSIONS: Manual G-2, M-5, Pt. VI, GEM Program Guide, dated August 25, 1992, is rescinded.

6. RECERTIFICATION: This VHA Handbook is scheduled for re-certification on or before the last working day of February 2010.

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DISTRIBUTION: CO: E-mailed 2/4/04
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 2/4/04

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides guidance for clinical and administrative staff in developing and operating geriatric evaluation and management (GEM) programs.

2. BACKGROUND

a. The Demographic Aging Imperative

(1) The aging of the United States (U.S.) population has been well documented. Reductions in the death rate in children and young adults worldwide during the 20th century, combined with a declining birth rate in most industrialized countries, has resulted in rapid growth in the absolute number and proportion of those living into their seventh, eighth, and ninth decades. The older adult population in the U.S. will double over the next 30 years to represent nearly 70 million people, or 25 percent of the total population. The aging of the veteran population has outpaced that of the general U.S. population in the last decade due the large proportion of veterans who are survivors of the Second World War and the Korean conflict. Between 1980 and 1990, while the total veteran population declined by about 5 percent, the proportion of veterans age 65+ increased from about 11 percent to 27 percent, representing 7.2 million individuals. Based on current data (as of September 30, 2002), over 38 percent of the U.S. veteran population is aged 65 and older. It is estimated that over the next 30 years, the percentage of veterans age 65+ will increase to represent 54 percent of the veteran population.

(2) Persons who survive to advanced age are more likely than younger individuals to live with chronic disease and disability, and to evidence more advanced states of the progressive effects of diminished physiologic resiliency. As such, a large proportion of the aged population requires on a regular basis health care services and assistance with activities of daily living. As a group, veterans experience more chronic disease and disability, requiring the Department of Veterans Affairs to plan for growing health demands by aging veterans, and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner (Besdine et al., 1984).

b. The Growth of Geriatric Evaluation

(1) The concepts of comprehensive geriatric evaluation, and of specialized geriatric evaluation and management programs, were first developed in Great Britain during the 1930's largely through the work of Dr. Marjory Warren. Dr. Warren was able to discharge home a large number of chronically ill, elderly patients at a large London infirmary for the indigent--patients who were previously thought to lack rehabilitation and discharge potential--through systematic evaluation and appropriate treatment of their disabling conditions. Based on her experiences, Dr. Warren advocated the establishment of special geriatric units in hospitals for the purpose of assessing and treating the chronically ill elderly before admitting them to long-term care homes (Warren, 1946). An interdisciplinary team that has the input of medicine, nursing,

social work, and rehabilitation therapy, she noted, should undertake the assessment and care of these patients. Subsequently, access to the skills of the geriatric hospital list, geriatric nursing home specialists, and geriatric community care specialist has become the norm in Great Britain and other European countries (Vetter et al., 1984).

(2) Interest in geriatric medicine, gerontology, and the concept of geriatric evaluation came later to the United States. The National Institute of Aging was established in 1973 to provide research grants to innovative researchers with interest in aging and gerontology. The Veterans Health Administration has long been a leader in geriatric health care and innovative geriatric programs, including GEM. Eugene J. Towbin, M.D., Chief of Staff at the Little Rock VA Medical Center from 1968-1996, was instrumental in establishing the first VA GEM unit there in 1974 (Fozard et al., 1985).

(3) The Veterans Health Administration appointed its first Chief for Extended Care in 1973 (expanded to Chief of Geriatrics and Extended Care in 1980), whose vision was to address the aging demographic imperative in three strategic ways:

(3) VA established Geriatric Research, Education and Clinical Centers (GRECCs) to integrate an aging research focus with training of staff and students, and development of new clinical models. Impetus for these programs stemmed from Dr. Towbin's advocacy and vision as well. The first eight GRECCs were designated between 1975 and 1980. In fact, the initial strong interest in geriatric evaluation programs both within and outside VA grew largely from groundbreaking evidence of the effectiveness of an innovative, inpatient GEM program tested in a randomized controlled trial at the VA Sepulveda GRECC (now part of the VA Greater Los Angeles Healthcare System) (Rubenstein et al., 1980).

(4) VA established 2-year geriatric medicine fellowship programs at multiple sites beginning in 1978 to train physicians in clinical care of the older patient. These early programs were essential training sites for individuals who later became leaders in the field of geriatric medicine and gerontology. To this day, VA remains a leader in geriatric and gerontology training. (Goodwin and Morley, 1994).

(5) VA established twelve Interdisciplinary Team Training in Geriatrics sites in the 1970's and 1980's to help foster the essential geriatric concept of the vital nature of an interdisciplinary approach to care of the older patient. Interdisciplinary team training remains at the core of the VA's geriatric mission.

c. **Legislation Related to Geriatric Services in VA.** Several key pieces of legislation have fostered the growth of geriatrics, gerontology and geriatric evaluation programs in VA; just a few of these are mentioned here. In 1980, Public Law 96-330 authorized VHA to establish up to 15 GRECCs and directed the creation of a Geriatrics and Gerontology Advisory Committee, charged with advising the Secretary of Veterans Affairs on matters of geriatrics and gerontology and with evaluating and monitoring existing and future GRECCs. In 1985, the VA budget specifically allocated funds for expansion of GEM programs, largely based on the successful findings of the early inpatient GEM units at the VA GRECCs in Sepulveda, CA and Little Rock, AR. That same year, Public Law 99-106 authorized the expansion of the GRECC program to up

to 25 sites. In 1999, Public Law 106-117, the Veterans Millennium Benefits and Healthcare Act, specified that access to outpatient geriatric evaluation was a service mandated for inclusion in the veterans standard benefits package.

d. **Evidence for Efficacy of Geriatric Assessment and GEM Programs.** Much of the research on the effectiveness of geriatric assessment and GEM programs has been conducted in VA. In the inpatient hospital setting, early single-site studies found dramatic benefits in terms of improved survival and functional status with programs involving comprehensive geriatric assessment and management (e.g., Applegate et al, 1983; Williams et al., 1973). However, in a more recent large VA trial which enrolled frail, hospitalized veterans aged 65 and older, participants were randomized to inpatient geriatric units or usual inpatient care, and then upon discharge were randomized into either: a) what might be considered low-intensity, outpatient geriatric clinics; or b) to usual outpatient care. This study demonstrated no significant effects on survival (perhaps because of improvements in usual care since the time of the earlier studies). However, there were significant reductions in functional decline with inpatient geriatric evaluation and management and improvements in mental health with outpatient geriatric care, with no increase in costs. The authors of this important trial and other experts have justifiably suggested that maintenance of quality of life and functional status in older patients are at least as important as survival benefits, particularly if these benefits are cost-neutral (Cohen et al., 2002).

(1) In a study on a non-VA population (Boult et al., 2001), the impact of comprehensive assessment followed by interdisciplinary primary care in 568 community-dwelling Medicare beneficiaries age 70 and older who were at high risk for hospital admission was judged according to functional ability, restricted activity days, bed disability days, depressive symptoms, mortality, Medicare payments, and use of health services. Participants were significantly less likely than controls to lose functional ability, to experience increased health-related restrictions in their daily activities, to have possible depression, or to use home health care services during the 12 to 18 months after randomization; although mortality, use of most health services, and total Medicare payments did not differ significantly between the two groups. The authors concluded that targeted outpatient GEM is successful at slowing functional decline.

(2) Factors that seem to play a role in the success of geriatric assessment programs include appropriate selection of participants to avoid older people who are “too sick” to benefit, and active involvement in the implementation of management by the geriatric care team (American Geriatrics Society Public Policy Committee, 1989). With inpatient units, it is also important to avoid patients who are “too well” to justify the higher cost of the added hospital days.

3. DEFINITIONS

a. **Geriatric Evaluation and Management (GEM)**

(1) Geriatric evaluation and management is a specialized program of services provided by an interdisciplinary team of health care professionals in either an inpatient or outpatient setting.

(a) The geriatric evaluation component consists of a comprehensive, multidimensional evaluation on a targeted group of older patients who will most likely benefit from these services.

(b) The management component of GEM consists of the development of an interdisciplinary plan of care, including treatment, rehabilitation, health promotion and social service interventions; and the commitment of key personnel including physician, nursing, social work and rehabilitation staff, as well as administrative support. ***NOTE:*** *The presence of an inpatient GEM, outpatient GEM, or both programs depends largely on identification of a need for such services and the availability of resources necessary to staff and support of these programs.*

(2) Depending on the mix of the population served, the bed section of the inpatient GEM unit may be in acute, intermediate, or nursing home care. Acute care is a suitable selection for a population with a high proportion of sub-acute care needs, if the generally longer length of stay for GEM patients, in comparison with that of acute care patients, is acceptable to facility management. Length of stay for an inpatient GEM should average between 15 and 30 days. A case mix that more strongly favors patients with rehabilitation needs may more suitably be part of the nursing home care unit. A patient population that combines elements of both may be suitable for intermediate care, although either of these latter choices will necessitate completion of the Minimum Data Set for each patient and the program will be subject to Long-term Care standards of JCAHO. Managers must be careful to make the decision of GEM bedsection based on what best suits the patient population, and not for purposes of purely administrative advantage.

b. **Inpatient GEM.** Inpatient GEM programs generally provide comprehensive assessment and management for frail older people who either have had a recent illness requiring acute hospitalization, or outpatients who have had significant functional decline or the development of other geriatric syndromes (e.g., dementia, delirium, urinary incontinence, gait and balance impairment, falls) that cannot be adequately addressed in the ambulatory care setting. Some inpatient GEM programs accept older patients with ongoing acute illness, but many prefer to transfer the older patient to the inpatient GEM unit after acute problems have been addressed.

c. **Outpatient GEM.** Outpatient GEM programs generally provide comprehensive assessment and management for older people who are likely to benefit from the services offered, with care provided either on a consultative basis or with referral to ongoing care in a geriatrics primary care clinic. Outpatient GEM programs focus on the coordinated, interdisciplinary provision of medical, nursing, psychosocial, and ongoing and preventive health services; health education to patients and caregivers; referral for specialty, rehabilitation and other levels of care; and follow-up and overall care management by geriatric primary care providers if appropriate. The spectrum of patients served may vary depending on the program structure. All inpatient programs and many outpatient programs focus on the evaluation and management of frail, medically complex patients. However, some outpatient programs place an equal emphasis on health promotion and disease prevention and target a broader array of patients for their services, especially the many older adults with pre-clinical disability and potentially alterable health risks (which may include a majority of older adults who tend to be overly sedentary or maintain other adverse health habits). To assist the tracking of GEM care it is highly encouraged that stop code (329) Outpatient GEM be used. GEM services may also be provided in Geriatric Primary Care (stop code 350) or Geriatric Specialty Care Clinic (stop code 318).

4. GOAL AND SCOPE

The goal of GEM programs is to assess and address, in an interdisciplinary manner, the biopsychosocial status of frail older persons with the intention of optimizing their health, function, and ability to live with the greatest degree of independence suitable for their situations. GEM programs provide geriatric evaluation and management, which generally involve comprehensive, multidimensional, interdisciplinary assessments of the older veteran's physical health, mental health, and functional and socioeconomic status. GEM programs have been provided in a variety of settings within VA, and this Handbook covers both inpatient and outpatient GEM programs.

5. DETERMINING NEED FOR GEM SERVICES

Data that might be reviewed in considering the need for an inpatient and/or outpatient GEM program in a particular VA center or geographic area include:

a. Number of enrolled veterans 65 years of age and older;

b. Number of enrolled veterans 65 years old and older with some functional decline based on the latest VET POP statistics ("Veterans Enrolled Population" data, which is broken out by age, county of residence, and other descriptors) and current trends in disability declines;

c. Available VA and community services for seniors as well as gaps in geriatric services; and

d. Availability of VA staff qualified in geriatrics at the VISN and facility level.

6. STAFFING CONSIDERATIONS

The professional literature has not reported on the strengths and weaknesses of different staff mixes for GEM programs. In the event the results of such investigations become available, managers should strive to conform to the most advantageous configuration. Programs that have demonstrated favorable patient outcomes have included personnel as follows:

a. **Core Team Members**

(1) The GEM is to be staffed by an interdisciplinary health care team with a core of at least a physician, social worker, nurse(s), and GEM Director (who may be one of the aforementioned health professionals) each of whom is skilled in the assessment and treatment of elderly patients.

(2) The core team may be expanded to include representatives from other services, such as pharmacy, geriatric psychiatry, psychology, dietetics, dentistry, physical medicine and rehabilitation, podiatry and optometry depending on patient population, major focus of activity, level of commitment to the program, and available expertise.

b. **Core Team Size.** The size of the core team depends on type and size of the program. Inpatient GEM programs generally require a larger staff than outpatient GEM programs. Disciplines listed in the preceding paragraph may function as core or as support staff to the GEM. Programs should strive to include a diverse membership and avoid making an assumption that the core team will always be able to recognize and act on the need for additional expertise. A core team composed of the minimal mix of disciplines listed in preceding subparagraph 6a is necessary to effect suitably comprehensive decision-making; the addition of other disciplines may make the process less streamlined but will generally offset that by widening the range of expertise participating.

c. **Time Availability of Staff.** Each member of the core team must have sufficient time to adequately conduct patient assessment, participate in interdisciplinary team meetings, contribute to the development of treatment plans, and fulfill other expected, discipline-specific GEM duties.

d. **Team Meetings**

(1) **Patient Care Team Meetings.** Team meetings provide a regular opportunity to discuss patients' status and develop and assess plans of care through an interdisciplinary exchange and synthesis of clinical information. Each member of the core team should regularly participate in team meetings to contribute to the development and assessment of treatment and discharge plans. Team meetings in the inpatient setting are generally more formal and involve specific documentation needs, while team meetings in the outpatient setting may be more informal, even to the point of being conducted "virtually" through the use of telephone conferences, telehealth technology, and meeting software. The program should develop a policy on the frequency of, attendance requirements for, and protocol of meetings.

(2) **GEM Staff Meetings.** GEM programs, particularly inpatient programs, also benefit from periodic, scheduled staff meetings to:

(a) Review the process of care in the program;

(b) Foster productive staff interaction; and

(c) Maintain a productive working team environment.

7. EDUCATIONAL MISSION

Each member of the core team and support staff should participate in the training of students and health professionals relating to the specialized needs of older patients, in order to maximize the benefit of GEM and to disseminate principles of geriatric care to other areas of the VA health care center.

8. RESPONSIBILITIES OF THE GEM DIRECTOR

The GEM Director performs relevant discipline-specific assessment and treatment duties in addition to the following duties:

a. Assuming overall administrative responsibly for the GEM;

b. Assuring a high standard of service by ongoing review of each staff member's performance and effectiveness;

c. Assuming responsibility for planning and recommending training of GEM staff;

d. Coordinating GEM-based education of other VA staff and trainees on geriatric medicine and gerontology principles;

e. Keeping facility top management and all other relevant staff informed about GEM activities; and

f. Coordinating efforts to promote the activities of the GEM throughout the facility and the community.

9. RESPONSIBILITIES OF THE GEM PHYSICIAN

The GEM Physician (includes attendings, fellows, residents and physician assistants) is responsible for:

a. Assuming primary medical responsibility for GEM patients;

b. Directly performing or supervising the medical evaluation and care of patients in the program (may delegate some duties to other providers with special geriatrics/gerontology training); and

c. Providing patient and family education.

10. RESPONSIBILITIES OF THE GEM NURSE

The core team nurse member ideally should have advanced nursing training, e.g., be a Nurse Practitioner or Clinical Nurse Specialist. In addition, this person is responsible for:

a. Collecting data on patient health and functional status systematically and in an ongoing manner;

b. Identifying patient problems based on the health and functional status data collected;

c. Contributing to, implementing, and coordinating the plan of care by:

(1) Providing geriatric consultation throughout the facility and arranging transfer to the GEM for those patients meeting admission criteria;

(2) Providing patient and family education; and

(3) Coordinating patient care with other team members during interdisciplinary team meetings.

d. Inviting the participation of patients and/or significant others in the ongoing processes of:

(1) Assessment

(2) Setting of goals; and

(3) Development and revision of the interdisciplinary plan of care.

e. In an inpatient GEM, assisting patients, family, and/or significant others in planning for discharge of the patient to the most appropriate setting.

11. RESPONSIBILITIES OF THE GEM SOCIAL WORKER

The GEM Social Worker is responsible for:

a. Providing a comprehensive psychosocial assessment and establishing contact with patient's family and/or significant others for all inpatient GEM patients and, as needed, for outpatient GEM patients;

b. Arranging family meetings with appropriate team members to facilitate effective communication of team plan to the patient and the family;

c. Serving as a consultant to GEM and other staff concerning the impact of social and emotional problems on older patient functioning;

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

e. Providing patient and/or family education, and

(1) In inpatient GEM programs, for:

(a) Providing linkage and networking with VA services and community agencies to facilitate the discharge planning process; and

(b) Assisting the patient, family and/or significant others plan for the patient’s discharge to a community setting that fosters the most suitable degree of independence.

(2) In outpatient GEM programs, for:

(a) Providing linkage and networking with VA and community agencies to foster the most suitable degree of independence in the community; and

(b) Promoting psychosocial well-being of patient's significant others by offering caregiver support and referral.

12. RESPONSIBILITIES OF THE GEM GERIATRIC PSYCHIATRIST

The Geriatric Psychiatrist is responsible for:

a. Assessing and contributing regarding diagnosis and treatment to development of plans of care for patients with combined medical-psychiatric, mixed cognitive, affective, substance dependence, and/or character disorders;

b. Serving as consultant to the GEM Director and team members for complex biopsychosocial patient issues; and

c. Educating GEM staff, patients, and families and/or caregivers with regard to assessments, treatment and management of biopsychosocially complex cases.

13. RESPONSIBILITIES OF THE GEM PSYCHOLOGIST

The GEM Psychologist is responsible for:

a. Screening all GEM inpatients and specific GEM outpatients for cognitive, emotional and behavioral problems, and providing a comprehensive psychological assessment when appropriate;

b. Alerting team to the need for consultation with a geriatric psychiatrist or neurologist for patients with multiple medical or combined medical-psychiatric problems, when appropriate;

c. Involving patients' families, and/or significant others in the psychological assessment, treatment and management process, when appropriate; and

d. Serving as a consultant to the GEM Director and team members to assist in resolving interpersonal conflicts and streamlining function within the GEM team.

14. RESPONSIBILITIES OF THE GEM DIETITIAN

The GEM Dietitian is responsible for:

a. Performing nutritional assessments and contributing to development of the plan of care;

b. Monitoring and evaluating the medical nutrition therapy for elderly inpatients and outpatients when appropriate; and

c. Educating GEM staff, patients, and significant others about the special nutritional needs of older persons.

15. RESPONSIBILITIES OF THE GEM PHARMACIST

The GEM Pharmacist is responsible for:

a. Monitoring and evaluating the process and outcome of drug therapy through the application of principles and practice of clinical pharmacokinetics, clinical pharmacy and pharmacology;

b. Assisting in the development of drug regimens tailored to each patient's needs;

c. Reviewing drug regimens of GEM patients for any potential interactions, interferences, or incompatibilities;

d. Participating in ongoing education of the GEM staff, particularly physicians and nurses, regarding drug problems in older people; and

e. Providing patient and/or family education regarding medications and compliance with prescribed drug regimen.

16. RESPONSIBILITIES OF THE GEM DENTIST

The GEM Dentist is responsible for:

a. Screening all inpatient GEM patients and appropriate GEM outpatients for oral and oropharyngeal disease and dysfunction, including an assessment of any oral appliances;

b. Providing more detailed assessment and treatment as necessary and possible within the guidelines of dental eligibility; and

c. Educating GEM staff, patients, and significant others on the significance of oral disease or dysfunction and the maintenance of oral health in older persons.

17. RESPONSIBILITIES OF THE GEM PHYSICAL MEDICINE AND REHABILITATION THERAPIST

The GEM Physical Medicine and Rehabilitation Therapist is responsible for:

a. Contributing to the assessment of patients' level of function and the instruction of patients and their families on approaches to improve functioning;

b. Participating in the development of daily or weekly programs to improve and/or maintain GEM patients' functioning; and

c. Providing expertise in long-term rehabilitation of GEM patients, including physical, occupational, kinesio-, recreational, and speech therapy, as indicated.

18. SELECTING APPROPRIATE PATIENTS

As noted above, most research suggests that GEM programs are most successful if the interventions are targeted to appropriate older veterans based on the services being provided. There is little support for a simple age-based criterion for enrollment in GEM programs that have as their focus the evaluation and management of frail, medically complex patients, although there is a notable increase in the prevalence of geriatric conditions among the oldest old. While age may be useful as a general guide for screening or for targeting appropriate patients, the use of age as a strict inclusion or exclusion criteria is controversial. The goal of any system of inclusionary criteria is to target GEM programs (particularly inpatient programs) to those older people most likely to benefit from the services offered.

a. **Inpatient GEM Services.** There is general agreement on the following inclusionary and exclusionary criteria for inpatient GEM services:

(1) **Inclusionary Criteria.** Patients who might best benefit from inpatient GEM are most likely to be age 65 years and older and have either:

(a) Multiple medical, functional and/or psychosocial problems, who could benefit from an interdisciplinary team approach; or

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

(2) **Exclusionary Criteria.** Patients who might best be excluded from inpatient GEM are those who meet any one of the following criteria:

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

(b) Have a well-documented terminal illness with a life expectancy less than 6 months (e.g., metastatic malignancy, end-stage congestive heart failure or end-stage cirrhosis).

(c) Need total care (e.g., severe irreversible dementia, severe cerebral vascular accident); and either:

1. Have an inadequate social support network to allow for eventual return home; or

2. Lack suitable rehabilitation potential to allow for permanent discharge to other than a nursing home setting.

(d) Have an active substance abuse disorder; or

(e) In the absence of depression or cognitive impairment, demonstrates a lack of motivation or has a documented refusal to participate in interdisciplinary evaluation and treatment plan.

b. **Outpatient GEM Services.** There is less agreement on the inclusionary and exclusionary criteria for outpatient GEM. This is largely due to variation in patient needs, available resources, program focus, and availability of geriatric and gerontology expertise and travel distances. In addition, many of the exclusionary criteria for inpatient GEM are not as relevant for outpatient GEM. Therefore, the suggested inclusionary and exclusionary criteria listed below might not be appropriate in all outpatient GEM programs, and should be regarded more as guidelines than strictly required characteristics.

(1) **Inclusionary Criteria**

(a) For all programs, given the universal focus on evaluation and management of frail, medically complex patients, the inclusion criteria are recommended to target patients aged 65 years or older that have either:

1. Multiple medical, functional and/or psychosocial problems, who could benefit from an interdisciplinary team approach; or

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

(b) For programs that also include a strong focus on health promotion and disease prevention, the inclusion criteria may also include the many older adults with pre-clinical disability and potentially alterable health risks.

(2) **Exclusionary Criteria.** Patients who might best be excluded from outpatient GEM are those who meet either of the following criteria:

(a) Homebound and might best be managed by other services, such as Home Based Primary Care; or

(b) Currently residing in a nursing home, and both patient and family are satisfied with the placement and the care provided there.

19. STRUCTURE OF THE CLINICAL EVALUATION PROCESS

a. **The Comprehensive Assessment.** A comprehensive geriatric evaluation begins with team members obtaining a detailed medical, psychosocial and medication history. This is reviewed by the interdisciplinary team alongside the findings of a current, full physical, psychological, and functional assessment; evaluations of the support, dietary, and living situations; and clarifications of patient and family/caregiver expectations. In this way, a current and complete problem list and a comprehensive interdisciplinary plan of care is developed.

b. **First Component of the Evaluation.** Patients referred to the GEM program are likely to differ in the number and complexity of their health-related problems and thus their need for specialized evaluations. This would be especially true of outpatient GEMs that include a health promotion/disease prevention focus. Consequently, programs may differ in the core group of health professionals involved in the first phase of the evaluation of all GEM referrals, and in the

structure and components of this first-phase or basic evaluation. This might include the administration of specific screening instruments as well as the completion of a detailed history and physical exam. Additional evaluation components and additional health-related professionals may be needed in the evaluation of a given patient who completes the basic evaluation. In this way, the GEM evaluation process can be tailored to the needs of each individual patient, although everyone will complete certain basic components.

c. **In-depth Evaluation Tailored to the Individual Patient.** The timeframe in which, and mechanism by which all of the needed evaluation components are completed and the appropriate management plan devised may vary from patient to patient. In many cases in outpatient GEM, one or more additional patient visits may be necessary. The mechanism by which the results of all evaluations are shared by the core team should also be defined, as well as who is(are) responsible for synthesizing the results into an appropriate management plan. As stated, face-to-face core team meetings may be utilized for this process, especially in the inpatient setting. In the outpatient setting, other mechanisms of communication may be utilized with face-to-face meetings reserved for evaluating program effectiveness and troubleshooting when problems are identified.

d. **Supply and Demand Issues for the Outpatient GEM.** A disparity between the large number of elderly veterans for whom geriatric assessment is indicated on the one hand, and the limited number of clinicians with specialty-level expertise in geriatrics on the other, is generally encountered as the value of the GEM to the health care system becomes recognized and demands on the program grow. The team has three possible approaches to this situation.

(1) The team may decide to restrict its activities to assessment. Management recommendations are communicated to the primary care provider to carry out. The published literature reflects poor compliance with such recommendations and outcomes that are not substantially improved when geriatric assessment is performed on a consultative basis, without direct implementation of recommendations (Struck et al., 1993). This approach is discouraged.

(2) The team may opt for restrictive admission criteria, in order to limit the cases they see to those that are the most challenging and least likely to experience optimum outcomes without the specialty assessment and management. This approach is most typically adopted where there is limited likelihood that additional staff will be provided as the program grows.

(3) The team may accept the growing workload without restriction in exchange for guarantees that staff increases will keep pace with the clinical load. This approach is generally adopted at larger academic centers where there is abundant geriatrics expertise.

e. **Focus on the Family and/or Caregiver.** The patient's family and/or other caregivers often play a vital role in helping the patient to maintain the highest possible level of health and functional independence. It is important to include as a part of the GEM evaluation an assessment of the strengths, desires, limitations, and needs of the family and/or caregivers. The extent of this evaluation needs to again be tailored to the needs of the individuals involved. Likewise, the management plan should also include efforts to partner with the family and/or caregivers as appropriate. This can be done through such means as providing moral support, training, and education resources, addressing questions and concerns, making referrals for respite

and home services when necessary, and giving guidance on navigating through appropriate health care and social support systems.

20. PROGRAM EVALUATION AND PERFORMANCE IMPROVEMENT

a. Program evaluation and performance improvement activities are vital components of GEM program function, and adequate staff time should be provided to perform these activities. Both depend on clear delineation of measurable program objectives, ongoing procedures for monitoring corresponding specific care processes and outcomes, and regular analysis of findings.

(1) Measurable program objectives include such parameters as:

(a) Improved diagnostic accuracy;

(b) Reduced placement in nursing homes;

(c) Improvement in physical and/or psychosocial functioning, with the exception of those patients with a diagnosis indicative of progressive decline;

(d) Improvement in medication utilization;

(e) Establishment of coordinated interdisciplinary care plans; and

(f) Facilitation of geriatric education and research.

(2) Techniques for monitoring these involve the regular collection and analysis of data, that may include**:**

(a) Diagnoses;

(b) Functional status changes;

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

(d) Medication usage;

(e) Completion of advance directives;

(f) Reduced number of alterable health risks;

(g) Patient and caregiver satisfaction surveys;

(h) For in-patient GEM only – length of stay;

(i) For education only - number, disciplines, and origins of trainees, number of hours, changes in attitudes, behaviors, and/or outcomes; and

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

b. Performance improvement activities for the GEM Program need to be coordinated with the Quality Management office at the facility, and reviewed by the same medical center leadership board that is responsible for oversight of all performance improvement activities at the facility. Program evaluation and research studies conducted in the GEM should be coordinated with the facility research office and research review committees.

21. STAFF TRAINING

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

a. **Local Resources.** Ongoing training should involve utilization of local resources whenever possible. Use of technology such as videoconferencing and telecommunication may help GEM personnel obtain initial training, as well as provide opportunities for ongoing professional enrichment through exchange of ideas locally, regionally and nationally.

b. **Other VA Medical Centers.** Interfacility educational details should be employed to observe the functions of established GEM programs. It is also recommended that experienced VA personnel be invited to visit a facility contemplating a new GEM program for the purpose of program planning and staff training.

c. **GRECCs.** The GEM model was originally developed and evaluated by two GRECCs in the 1970's and has continued to serve as a dominant setting for geriatric care, education/training, and research at most GRECC sites. GRECC staff can serve as an excellent resource to a VA medical center establishing a new GEM program, one seeking outside evaluation of its existing program, or one considering changes in its current GEM.

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