Department of Veterans Affairs **VHA HANDBOOK 1140.07**
Veterans Health Administration
Washington, DC 20420 **September 25, 2008**

GERIATRIC PRIMARY CARE

1. PURPOSE. This Veteran Health Administration (VHA) Handbook provides the procedures for workload reporting and quality assurance options for Geriatric Primary Care programs in VHA facilities.

2. SUMMARY OF MAJOR CHANGES. This new Handbook describes the scope, goals, target population, workload reporting, and quality assurance options for Geriatric Primary Care Programs.

3. RELATED ISSUES. VHA Handbook 1140.4.

4. FOLLOW-UP RESPONSIBILITIES. The Chief Consultant for Geriatrics and Extended Care (114), in the Office of Patient Care Service (PCS) is responsible for the contents of this Handbook. Questions may be addressed to (202) 461-6770.

5. RESCISSION. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of September 2013.

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the scope, goals, target population, workload reporting, and quality assurance options for Geriatric Primary Care programs in VHA facilities.

2. BACKGROUND

a. Public Law 106-117, "The Millennium Act," authorized VHA to expand access to non-institutional alternatives to long term care. As intended this has resulted, during the first decade of the new millennium, in an unprecedented number of veterans of advanced age being able to remain in their homes and communities despite significant health care needs. Many of these veterans receive Department of Veterans Affairs (VA) medical center-based outpatient services. In Fiscal Year (FY) 2007, nearly 53 percent of the 3.8 million veterans who received primary care in VA were age 65 years or older. In addition to their multiple medical problems, many had functional and cognitive impairments that dramatically increase in prevalence and severity with age and markedly impact patient care. Veterans over age 85 years, the fastest growing component of VHA's target group, represent the most cognitively and physically-disabled subset of the elderly veteran population, with over half having a diagnosis of a dementing illness and requiring daily assistance in self-care.

b. Geriatric Primary Care (GPC) offers enhanced expertise for managing patients with particularly challenging geriatric health concerns. GPC integrates and coordinates traditional ambulatory and institution-based health care services with a variety of community-based options for optimizing an older person's independence and quality of life despite compounding cognitive, psychosocial, and medical impediments. GPC involves GPC providers and interdisciplinary team members who have advanced training in treating the illnesses frequently faced by elderly patients (in the context of these impairments), and are skilled at assessing and addressing geriatric syndromes and the wide range of factors complicating geriatric health management. Close collaboration between Primary Care and GPC within a health care system, involving scheduling, staffing, referral criteria, and transfer arrangements, is essential for optimal patient care.

3. DEFINITIONS

a. **GPC.** GPC is the integrated longitudinal management of the health care needs of elderly patients by a GPC provider, provided to older patients with a range of needs. At one end of this spectrum are those relatively healthy seniors who desire the services of a provider whose professional interests are focused exclusively on care of the elderly. At the other end of the spectrum are the most frail, complex, and challenging elderly patients who require a primary care provider (PCP) with specialized-clinical expertise plus familiarity with the range of community services and other support mechanisms necessary to provide integrated care to those of advanced

age whose lives are marked by coexisting functional, social, cognitive, and medical problems. The limited supply of trained geriatric personnel in VHA dictates that most GPC activity in VA needs to concentrate on veterans closer to the latter end of the scale. GPC is distinct from "geriatric consultation," which is a one-time assessment with recommendations for management, assistance in determining decision-making capacity for medical treatment or selection of living arrangement, or time-limited case management on behalf of a frail elderly patient. These services for outpatients may be provided through the GPC clinic, but are themselves not GPC.

b. **GPC Provider.** A GPC provider is a physician, physician assistant, or nurse practitioner who has received training and certification in, or who has had extensive supervised clinical experience in the management of patients of advanced age with chronic disease compounded by psychosocial and functional issues, in collaborative partnership with an interdisciplinary team of suitably prepared health care professionals.

c. **Geriatric Syndrome.** Geriatric syndrome is the general term for any one of a set of variable clinical states of dysfunction. The clinical dysfunction includes heightened vulnerability observed among individuals of advanced age that is indicative of one or more underlying organic disease states combined with atypical presentation, functional impairment and likelihood of progression. Examples include "failure to thrive," delirium, falling, disorders of gait and balance, incontinence, dementia and impaired cognition, depression, polypharmacy, and malnutrition.

d. **Interdisciplinary.** "Interdisciplinary" is the term applied to a group or a process that involves health professionals of several disciplines operating synergistically.

(1) In the context of GPC, this includes geriatricians or suitably-prepared physicians, nurse practitioners, physician assistants, nurses, social workers, pharmacists, dieticians, mental health providers, and rehabilitation professionals. These individuals are experienced in working as a coordinated unit in the patient-centric assessment and management of complex and frail elderly individuals.

(2) Members of an interdisciplinary team have advanced training and experience:

(a) In addressing the discipline-specific, health-related challenges encountered in frail, chronically-ill veterans of advanced age;

(b) In communicating and collaborating effectively with health professionals from other health disciplines; and

(c) In communicating effectively with the population served, including elderly veterans and their caregivers.

(3) An interdisciplinary plan of care is more than the sum of individual disciplines' input because each interdisciplinary team member's familiarity with the range of contributions and the scope of expertise of every other team member gives rise to care plan elements that cross traditional discipline-specific boundaries in response to particular patient needs.

4. SCOPE

GPC is the assumption of primary care responsibility for the patient. This responsibility is initiated:

(1) When a new patient meets specified inclusion criteria and is assigned to the GPC Program as part of the health system's customary mechanism for assigning new patients to a PCP, or

(2) When a PCP chooses to transfer primary care responsibility to the GPC provider for a patient meeting specified inclusion criteria.

5. GOALS

GPC shares with usual primary care the fundamental standards of continuity, accessibility and timeliness, comprehensiveness, coordination, and practice in the context of family and community. Specific goals of GPC include:

a. Maintain each patient in the least restrictive environment;

b. Minimize the progression of chronic disease;

c. Minimize and optimize medication regimens;

d. Maximize function and quality of life in the face of chronic disease;

e. Enhance self-efficacy through education and respect for patient choices; and

f. Ensure a seamless progression from predominantly curative to more palliatively-focused chronic disease management when dictated by disease progression and patient preference.

6. RESPONSIBILITY

a. **Facility Chief of Staff.** The facility Chief of Staff is responsible for:

(1) Determining the number of clinic sessions devoted to GPC, and

(2) Ensuring the clinic sessions devoted to GPC are appropriately staffed and have suitable administrative support and clinical space.

(a) Because of the complexity of the patients served in GPC, the pro-rated full-time panel size of a physician geriatric provider must not exceed 2/3 the size for the facility's physician PCPs; and for non-physician geriatric providers, must not exceed 2/3 the size for the facility's independent non-physician PCPs. ***NOTE:*** *As with all panel size determinations, these limits may need to be decreased in the absence of adequate support staff or of multiple exam rooms.*

(b) Members of the interdisciplinary GPC team who can be expected to be in demand during a clinic session, such as the social worker and the pharmacist, should not just be available by phone, but need to be assigned to, and to be present at, that session of the clinic.

b. **Chief, Primary Care Service.** The Chief, Primary Care Service, or equivalent official, is responsible for working with the medical director of the GPC Program to explicitly define referral and inclusion criteria and to facilitate the communication of these to PCPs through provider agreements, periodic in-service educational programs, and other suitably effective means. The referral criteria chosen varies by site and is determined according to the extent of geriatrics expertise available.

c. **Medical Director, GPC.** The Medical Director, GPC, is responsible for working with the Chief of Primary Care to establish referral criteria and program focus and is also responsible for:

(1) Ensuring that complete, accurate, and timely GPC workload reporting occurs;

(2) Communicating findings and indicated actions to staff and facility leadership as appropriate;

(3) Establishing a quality assurance program for GPC; and

(4) Ensuring that the GPC program fully meets the standards for VHA Primary Care programs.

7. TARGET POPULATION

GPC focuses on a specified target population to take full advantage of the limited number of geriatric providers to maximize the benefits of these services to the health care system and (on behalf of other providers) to best serve the targeted patient population.

a. Acceptable inclusion criteria may include, but are not limited to, one or more of the following:

(1) Multiple medical, functional, and/or psychosocial problems, characteristically associated with advanced age, that are likely to benefit from assessment and management through an interdisciplinary team approach;

(2) One or more geriatric syndrome(s);

(3) Documentation of persistent suboptimal outcomes while managed in usual primary care (e.g., frequent ER visits, repeated hospitalizations, etc.) and a realistic potential for improvement if managed in GPC;

(4) Elder abuse or neglect; or

(5) Impending disability with potentially alterable health risks.

b. Proposed transfers of patients to a GPC panel are subject to approval by the Medical Director, GPC, who makes a determination as to whether such a transfer is likely to benefit the patient. Justification for refusals must be documented in the patients' medical record; for example, patients who are transferred due solely to non-compliance with Primary Care recommendations or solely for renewal of extensive medication lists. Cases of patients wishing to remain with their PCP, but still benefit from GPC input need to be managed through a mechanism of geriatric consultation.

8. WORKLOAD REPORTING

GPC is counted by Stop Code 350, "Geriatric Primary Care." A secondary code, S0250, must be added whenever an interdisciplinary geriatric evaluation and the development of a plan of care involving a Geriatric Provider and representatives of at least two other disciplines has been conducted during the encounter.

9. QUALITY ASSURANCE

a. GPC is tracked by the same panel of performance measures as primary care. Several of these measures are not tracked nationally for patients above a certain age because data from elderly subjects are insufficient to support a mandate for the particular clinical practice. Providers need to rely on their clinical judgment when deciding whether to subject a patient of any age, but particularly an elderly patient, to procedures or to target laboratory values for which a suitable evidence base in the relevant population is inadequate.

b. There are presently six Supporting Indicators tracked by the Office of Quality and Performance that the literature supports as appropriate quality indicators for outpatient care expressly for patients age 75 years and older. These Supporting Indicators, which may be useful for tracking impact of a GPC program on a health care system are:

(1) A record of a current screening for falls.

(2) A falls assessment for positive screens of current falls.

(3) A record of a current screening for urinary incontinence.

(4) A urinary incontinence assessment for positive screens in the current screening for urinary incontinence.

(5) A record of a current functional assessment.

(6) A record that discussion with the patient has occurred concerning the selection of a surrogate decision-maker.

c. GPC programs are encouraged to track the sources and justifications for referrals, consultations, and collaborations, in order to support an ongoing program of referral criteria

refinement and care process improvement, and to build a record that demonstrates patterns and extent of support to the health care system.

d. Due to its higher prevalence of cognitive impairment, a prominent subset of GPC patients may be at elevated risk for decline if follow-up appointments are denied them in the interest of supporting "same day scheduling." Health systems seeking enhanced access through performance measures based on minimal wait for appointments need to include provisions for situations in which appointments made far in advance are necessary for certain patients' longitudinal care.

10. REFERENCES

VHA Handbook 1140.4, "Geriatric Evaluation and Management Procedures."