VHA HANDBOOK 1140.09 Transmittal Sheet December 2, 2009

# **GERIATRIC CONSULTATION**

- **1. PURPOSE.** This Veterans Health Administration (VHA) Handbook describes the scope, goals, target population, and workload reporting for Geriatric Consultation programs in VHA facilities.
- **2. SUMMARY OF MAJOR CHANGES.** This is a new Handbook.
- **3. RELATED ISSUES.** VHA Directive 1140, VHA Handbook 1140.4, and VHA Handbook 1140.07.
- **4. FOLLOW-UP RESPONSIBILITIES.** The Chief Consultant for Geriatrics and Extended Care (114), in the Office of Patient Care Services (PCS) is responsible for the contents of this Handbook. Questions may be addressed to (202) 461-6770.
- **5. RECISSIONS.** None.
- **6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of December 2014.

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# **CONTENTS**

# **GERIATRIC CONSULTATION**

| PARAGRAPH   | PAGE |
|---|------|
| 1. Purpose  | 1    |
| 2. Background   | 1    |
| 3. Scope  | 1    |
| 4. Goals  | 2    |
| 5. Responsibility of The Facility Chief of Staff                          | 3    |
| 6. Responsibility of The Facility Associate Chief of Staff for Geriatrics | 3 3  |
| 7. Target Population  | 4    |
| 8. Workload Reporting   | 4    |

#### **GERIATRIC CONSULTATION**

#### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the scope, goals, target population, and workload reporting for Geriatric Consultation 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 in an unprecedented number of Veterans of advanced age being able to remain in their homes and communities despite significant health care needs. Yet at this time of unprecedented growth in demand for service by elderly Veterans, the supply of providers trained in geriatrics is markedly inadequate. In April 2008, The Institute of Medicine report entitled "Retooling the Health Care Workforce for an Aging America" documents this shortage, which is expected to worsen if present trends continue in physician specialty selection. Most Department of Veterans Affairs' (VA) care for elderly Veterans is being provided by primary care providers with no specialized training in geriatrics.
- b. This compelling demand for geriatric expertise, superimposed on the present and the projected undersupply of trained geriatricians, has dictated that these and related experts (physicians, nurse practitioners, and physician assistants with advanced clinical training or credential in geriatrics) must provide a unique blend of generalist and specialist roles. They need to be able to provide longitudinal primary care to the most frail and complex older Veterans. However, they must also be prepared to provide consultation to VA primary care and acute care colleagues on selected patients with geriatric issues, so that most of these patients may continue to receive care from their original providers. This second role is the focus of this Handbook.
- c. Geriatric Consultation may be provided on behalf of inpatients or outpatients. Consultation may be provided in response to a request for consultation by the managing team, or by the primary care provider (PCP), respectively. The consultation may be conducted during and within the setting of an outpatient clinic (e.g., Primary or specialty care), Geriatric Primary Care Clinic, Geriatric Problem-focused Clinic (termed "Geriatric Clinic" until 9-30-2009), Alzheimer's Dementia Clinic, Geriatric Research, Education and Clinical Center (GRECC), or Geriatric Evaluation and Management (GEM) Clinic; or bedside for inpatients. Some geriatric consultation services may be limited to a particular geriatric clinical entity, such as falls, incontinence, polypharmacy, and memory loss, etc.

# 3. SCOPE

Geriatric consultation is initiated by the treating team or PCP using the Computerized Patient Record System (CPRS). At a minimum, the response to the request (which may entail more than a single clinical interaction between the geriatric consultant and the patient) consists of a written assessment and recommendation for management, documented in CPRS. Once the consult has been answered, subsequent involvement with the patient on the part of the geriatrician consulted may occur:

- a. If the expectation for such involvement was part of the original terms of the request for consultation;
- b. If it is specified by the Service Agreement (see par. 6) in place between the consulting and consulted services (written agreement between potentially consulting and consultant services, consisting of the information needs of the consulted service, the expected results and timeframe of the consultation, and inclusionary and exclusionary criteria if any); or
- c. If the patient's care is subsequently transferred to one of the consultant's clinical programs (e.g., CLC, GEM Program, Home-Based Primary Care (HBPC), or Geriatric Primary Care).

**NOTE:** Several controlled trials described in the professional literature report that the outcomes stemming from geriatric consultation are significantly better when post-consult participation by the consultant occurs.

# 4. GOALS

Specific goals of geriatric consultation include:

- a. Improving efficacy and focus of the processes of care and optimizing clinical outcomes on behalf of elderly patients;
- b. Providing the requesting team or provider with a succinct assessment of the clinical situation and a practical recommendation or prioritized set of possible recommendations for management;
- c. Educating the requesting team or provider about the particular clinical issue so that the management skills of older patients in the future are enhanced;
- d. Seeking to instill key geriatric values into the subsequent management of all older patients' care, such as:
  - (1) Honoring patient choices,
  - (2) Promoting autonomy,
  - (3) Enhancing function and quality of life,
  - (4) Optimizing the medication regimen, and
  - (5) Reversing, halting, or reducing decline.

## 5. RESPONSIBILITY OF THE FACILITY CHIEF OF STAFF

The facility Chief of Staff, at a facility offering a program in geriatric consultation, is responsible for:

- a. Ensuring the necessary processes are in place for communicating requests for and responses to requests for geriatric consultation; and
- b. Staffing the facility such that responses to requests for geriatric consultation are provided by staff with appropriate expertise and occur in a timely manner.

# 6. RESPONSIBILITY OF THE FACILITY ASSOCIATE CHIEF OF STAFF FOR GERIATRICS

The Associate Chief of Staff for Geriatrics, the Section Chief of Geriatric Medicine, or the individual with corresponding expertise and responsibility at a facility is responsible for:

- a. Identifying and communicating with each potential requesting service (e.g., Surgery, Medicine, Physical Medicine, Neurology, Psychiatry, Mental Health, Ambulatory Care, and Primary Care) to establish a Service Agreement with each, or a less formalized understanding, that makes clear to both parties:
  - (1) The availability of Geriatric Consultation;
- (2) The range of patient presentations and concerns appropriate and inappropriate for initiating a request for geriatric consultation;
  - (3) The information that needs to be contained in a request for geriatric consultation; and
- (4) The limitations of the response and subsequent involvement with the case that is provided.
- b. Establishing and maintaining staffing, procedures, and processes that permit timely and informative responses to geriatric consultation requests in keeping with the documented or negotiated but informal agreements with the requesting services.
- c. Identifying, and where necessary, securing access to geriatric consultation services for providers in care settings in which geriatric consultation is not present on-site, such as Community-Based Outpatient Clinics. For such situations, options need to be explored in advance of the demand so that any eventual need, which might arise, may be addressed in a timely manner. These options include, but are not limited to:
- (1) Referral of the patient to another VA health care facility where such geriatric expertise may be available; or
  - (2) Contact with one or more consultants at a nearby GRECC. NOTE: A listing of GRECCs

and their links to contact information may be found at: http://vaww1.va.gov/grecc/page.cfm?=1. This is an internal site and is not available to the public.

d. Ensuring that staff that respond to consultation requests are aware of, and adhere to policy regarding the reporting requirements using the Healthcare Common Procedure Coding System (HCPCS) precedure code S0250 (see par. 8).

## 7. TARGET POPULATION

- a. Requests for geriatric consultation need to be limited to a specified target population in order to: take full advantage of the limited number of geriatric providers; maximize the benefits of these services to the health care system and on behalf of other providers; and best serve the targeted patient population.
  - b. Inclusion criteria may include, but are not limited to, one or more of the following:
- (1) "Geriatric syndromes," such as impaired cognition, urinary or fecal incontinence, gait or balance disorder, falls, or delirium;
- (2) Medical condition(s) whose management is (are) made particularly complex by advanced age, frailty, or one or more comorbidities or coincident conditions;
  - (3) Continuing decline in the face of ongoing management;
- (4) Consideration for extended care placement, such as: CLC, HBPC, Homemaker Home Health Aide, Respite, or Assisted Living;
  - (5) Concern over elder abuse or neglect; or
  - (6) Impending disability with potentially alterable health risks.
- c. Exclusion criteria may include, but are not limited to, a patient co-managed by a community provider requesting prescription renewal only.

## 8. WORKLOAD REPORTING

- a. Geriatric Consultation workload must be reported:
- (1) For an outpatient encounter, according to the setting in which the assessment is performed. This might include: Geriatric Primary Care Clinic (Stop Code 350, either position), Geriatric Problem-Focused Clinic (Stop Code 318, either position), Alzheimer's or Dementia Clinic (Stop Code 320, either position), GEM Clinic (319, either position), or GRECC Clinic (352, either position).
- (2) For an inpatient; through a progress note and, where employed, through Event Capture or inpatient encounter.

- b. The HCPCS procedure code, S0250, needs to be added whenever an interdisciplinary geriatric evaluation and development of a plan of care, involving a Geriatric Provider and representatives of at least two other disciplines, has been conducted during the encounter.
- c. The geriatric workload is not collected nationally, although events of geriatric evaluation, as reflected by the report of HCPSC procedure code are. *NOTE:* The Office of Geriatrics and Extended Care examines these reports quarterly to ascertain validity and completeness.