

## GERIATRIC EVALUATION AND MANAGEMENT (GEM) PROCEDURES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook provides procedures for clinical and administrative staff in developing and operating Geriatric Evaluation and Management (GEM) programs.
- 2. SUMMARY OF MAJOR CHANGES.** This revised Handbook has:
  - a. Updated definitions,
  - b. Revised roles for the GEM Provider, GEM Nurse, and GEM Psychiatric Provider, and
  - c. Guidance regarding geriatric evaluation workload reporting using the S0250 procedure code.
- 3. RELATED PUBLICATIONS.** VHA Directive 1140.
- 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 202-461-6750.
- 5. RECISSIONS.** VHA Handbook 1140.4, Geriatric Evaluation and Management Procedures, dated February 2, 2005, is rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of May 2015.

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## GERIATRIC EVALUATION AND MANAGEMENT PROCEDURES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides procedures and 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 during the 20th century combined with a declining birth rate has resulted in rapid growth in the absolute number and proportion of those living into their seventh, eighth, and ninth decades. Approximately 39.7 percent (8.97 million) of the 22.61 million Veterans in 2009 are over age 65; and 5.5 percent (1.25 million) are over age 85. Seven point 2 million Veterans of all ages are enrolled in the Department of Veterans Affairs (VA); 3.3 million (42.9 percent) of these Veterans are age 65 and over. In 2009, 52 percent of the Veterans who received care from VA were in this age group.

(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 aging population requires health care services and assistance with activities of daily living (ADL) on a regular basis. As a group, Veterans experience more chronic disease and disability, requiring VA 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 (see subpar. 25a.).

#### b. The Growth of Geriatric Evaluation

(1) The concepts of comprehensive geriatric evaluation were first developed in Great Britain during the 1940's largely through the work of Dr. Marjory Warren, who 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 (see subpar. 25b). 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.

(2) 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 (see subpar. 25c). Increased 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 Geriatric Research and Education Clinical Center (GRECC), which is now part of the VA Greater Los Angeles Healthcare System (see subpar. 25d).

c. **Legislation Related to Geriatric Evaluation in VA.** In 1999, Public Law (Pub. L.) 106-117, the Veterans Millennium Benefits and Healthcare Act, specified that access to geriatric evaluation was mandated for inclusion in the Veterans standard benefits package. *NOTE: This legislation mandated evaluation, but the intent of this Handbook is to describe programs in which that evaluation is paired with carrying out the resulting management plan.*

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.

(1) 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 (see subpar. 25e and subpar. 25f).

(2) In a VA trial that enrolled frail, hospitalized Veterans age 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) usual outpatient care. 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 (see subpar. 25g).

(3) In a study on a non-VA population (see subpar. 25h), 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 were 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 patients used as 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. 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.

(4) Factors that seem to play a role in the success of geriatric assessment programs include (for inpatient programs) appropriate selection of participants to avoid older people who are “too sick” to benefit, and patients who are “too well” to justify the higher cost of the added hospital days. For outpatient programs, active involvement in the implementation of management by the geriatric care team substantially enhances impact (see subpar. 25i and subpar. 25j).

### 3. DEFINITIONS

a. **Geriatric Evaluation and Management (GEM).** GEM is a specialized program of services provided by an interdisciplinary team of health care professionals, for a targeted group of predominantly older patients and others with medical complexity, who will most likely benefit from these services. Such services may be provided in an inpatient or outpatient setting, and include evaluation and management components.

(1) **Geriatric Evaluation Component of GEM.** The geriatric evaluation component consists of a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. Provision of geriatric evaluation, including the disciplines involved in the process, must be reported with the procedure code S0250, regardless of whether the service is provided as part of GEM (inpatient or outpatient) or another clinical program (e.g., Community Living Center (CLC), Geriatric Primary Care, etc.). **NOTE:** *For details on workload reporting for geriatric evaluation using the S0250 code, see Appendix A.*

(2) **Management Component of GEM.** The management component of GEM consists of treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel including: geriatric providers and nursing, social work, rehabilitation, and administrative staff.

b. **Geriatric Provider.** A geriatric provider is a physician, physician's assistant, or nurse practitioner who has received training or 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. The geriatric provider works in collaborative partnership with an interdisciplinary team of suitably prepared healthcare professionals.

c. **Interdisciplinary.** "Interdisciplinary" is the term applied to a group, or a process, that involves health professionals of several disciplines operating synergistically. In the context of Geriatric Primary Care this generally includes geriatricians or suitably-prepared physicians, nurse practitioners and physician assistants, nurses, social workers, pharmacists, dieticians, mental health providers, and rehabilitation professionals, all of whom are experienced in working as a coordinated unit in the patient-centric assessment and management of complex, frail elderly individuals.

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

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

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

(c) Communicating effectively with the population served, including elderly Veterans and their caregivers.

(2) 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**

GEM programs provide geriatric evaluation and management, which generally involves comprehensive, multidimensional, interdisciplinary assessments of the older Veteran's physical health, mental health, 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. Whether a formal inpatient GEM, a formal outpatient GEM, or a geriatric evaluation in the context of another program (e.g., Geriatric Primary Care or Home Based Primary Care (HBPC)) at a site depends largely on identification of a need for such services and the availability of resources necessary to staff and support these programs.

#### **5. GOAL**

The goal of GEM programs is to identify, assess, and address, in an interdisciplinary manner, the biopsychosocial status of severely disabled and frail older persons at risk for further decline and institutional placement, with the intention of optimizing their health, function, and ability to live with the greatest degree of independence suitable for their situations.

#### **6. DETERMINING GEM SERVICES TYPE**

a. "Geriatric evaluation" was explicitly mandated for inclusion in the Veterans benefits package by Pub. L. 106-117. In developing clinical programs to fulfill this requirement, facilities need to assess patient demand and available VA resources, as they determine the site or sites in which "geriatric evaluation" is delivered, e.g., whether through Primary Care, Outpatient GEM, Inpatient GEM, Geriatric Primary Care, HBPC, Geriatric Problem-Focused Clinic, or Alzheimer's Clinic.

b. Data reviewed in considering the preference for an inpatient or outpatient GEM program in a particular VA center or geographic area include:

(1) Number of enrolled Veterans 65 years of age and older;

(2) 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;

(3) Available VA and community services for seniors, as well as gaps in geriatric services; and

(4) Availability of VA staff qualified in geriatrics at the Veterans Integrated Service Network (VISN) and facility level.

#### **7. INPATIENT GEM PROGRAMS**

Inpatient GEM programs generally provide comprehensive assessment and management for older Veterans who either have had a recent illness requiring acute hospitalization, or outpatients who have had significant functional decline, or 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 patients with ongoing acute illness, but many prefer to transfer such patient to the inpatient GEM unit only after acute problems have been addressed.

a. Managers must be careful to make the decision of GEM bed section based on what best suits the patient population, and not for purposes of purely administrative advantage. Depending on the mix of the population served, the bed section of the inpatient GEM unit may be in acute care, psychiatric care, CLC, or rehabilitation.

b. Acute care may be a reasonable selection for a population with:

(1) A high proportion of subacute care needs that can be addressed in a limited number of days;

(2) Dominant mental health needs in the population targeted that favor location within Psychiatry; and

(3) A case mix that largely serves patients with rehabilitation needs may more suitably be part of the CLC (making necessary the completion of the Minimum Data Set for each patient) or an acute or subacute Rehabilitation setting.

## **8. OUTPATIENT GEM PROGRAMS**

Outpatient GEM programs generally provide comprehensive evaluation and management for older people 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 or primary care clinic.

a. Outpatient GEM programs focus on:

(1) The coordinated, interdisciplinary provision of medical, nursing, psychosocial, and ongoing and preventive health services;

(2) Health education to patients and caregivers;

(3) Referral for specialty, rehabilitation and other levels of care; and

(4) Follow-up and overall care management by geriatric primary care providers if appropriate.

b. 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).

c. GEM Clinic (Stop Code 319, either position) is used to track episodes of outpatient GEM.

d. Services equivalent to those provided in outpatient GEM may conceivably be provided in:

(1) Primary Care Clinic (stop code 323, either position);

(2) Geriatric Primary Care Clinic (stop code 350, either position);

(3) GRECC Clinic (stop code 352, either position);

(4) Home-Based Primary Care Clinics (stop codes 170 or 177, primary position);

(5) Alzheimer's and Dementia Clinic (stop code 320, either position); or

(6) Geriatric Clinic (stop code 318, either position).

e. When programs, listed in preceding subparagraphs 8d(1)-(6), include activities and personnel consistent with the definition of "geriatric evaluation" (e.g., led by an independent provider with advanced training or experience in managing complex geriatric patients; interdisciplinary assessment and development of plan of care with at least two other disciplines), a procedure code, S0250, must be entered to track geriatric evaluation workload.

f. An exception to subparagraph 8e occurs with HBPC. HBPC episodes of care that include geriatric evaluation must not be coded with S0250, even if geriatric evaluation has been conducted; for HBPC, there is an alternative, internal mechanism for accounting for this activity.

## 9. STAFFING CONSIDERATIONS

The professional literature has not reported on the strengths and weaknesses of different staff mixes for either inpatient or outpatient GEM programs. If the results of such investigations become available, managers need to strive to conform to the most advantageous configuration. However, programs to date that have demonstrated favorable patient outcomes have included personnel as follows:

### a. Core Team Members

(1) The GEM is staffed by an interdisciplinary health care team with a core of at least a geriatric provider, social worker, nurse(s), and GEM Director (who may be one of the aforementioned health professionals), each 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, 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. A core team composed of the mix of disciplines listed in preceding subparagraph 9a(1) is necessary for effective decision-making, but programs need to strive for memberships as diverse as possible. The need for active team participation needs to be emphasized to all members. Membership in excess of the minimum described in 9a(1) may make the process less streamlined, but broadens the range of contributing expertise.

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 core team member must regularly participate in team meetings, contributing to the development and assessment of treatment and discharge plans. Inpatient team meetings are generally formal because of the specific documentation needs involved, while outpatient team meetings may be informal, and even conducted "virtually" using telephone conferences, telehealth technology, and meeting software. The program needs to specify to members the frequency of, attendance requirements for, and the 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.

## 10. EDUCATIONAL MISSION

Each member of the core team and support staff needs to 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, if applicable.

## 11. RESPONSIBILITIES OF THE GEM DIRECTOR

The GEM Director needs to be a geriatrician, a non-geriatrician physician with advanced clinical training in the management of complex elderly patients, a nurse practitioner or physician assistant with advanced training in geriatrics; or other suitably-trained health professional who

can fulfill the following responsibilities, e.g., social worker, psychologist, etc. The GEM Director performs relevant discipline-specific assessment and treatment duties in addition to:

- a. Assuming overall administrative responsibility for the GEM;
- b. Ensuring 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 in geriatric medicine and gerontology principles;
- e. Keeping facility executive leadership 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.

## **12. RESPONSIBILITIES OF THE GEM GERIATRIC PROVIDER**

The GEM Geriatric Provider 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 or gerontology training);
- c. Providing patient and family education (may delegate as appropriate); and
- d. Promoting GEM throughout the facility; and
- e. Facilitating referral to GEM for those patients meeting admission criteria.

## **13. RESPONSIBILITIES OF THE GEM NURSE**

The GEM nurse is responsible for:

- a. Completing the nursing assessment to identify patient problems based on the health and functional status data collected;
- b. Contributing to, implementing, and coordinating the plan of care;
- c. Promoting GEM throughout the facility;

- d. Educating nursing and other staff on GEM principles, including the prevention of functional decline, the support of restorative goals of care, and implementation of evidence-based protocols for enhancing patient independence;
- e. Serving as a resource to nurse staff on less frequently encountered nursing cares, such as ostomy care and feeding tubes;
- f. Facilitating referral to GEM for those patients meeting admission criteria;
- g. Providing patient and family education;
- h. Facilitating interdisciplinary team meetings;
- i. Inviting the participation of patients and significant others in the ongoing interdisciplinary team processes of the assessment, development, and revision of the plan of care, and in the setting of goals; and
- j. In an inpatient GEM, assisting patients, family, and significant others in planning for the discharge of the patient to the most appropriate setting.

#### **14. 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 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 the 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 family education;
- f. Providing for Veterans receiving care through inpatient GEM programs by:
  - (1) Networking and linkage with VA services and community agencies to facilitate the discharge planning process; and
  - (2) Assisting the patient, family and significant others with a plan for the patient's discharge to a community setting that fosters the most suitable degree of independence.

g. Providing for Veterans receiving care through outpatient GEM programs by:

(1) Networking and linkage with VA and community agencies to foster the most suitable degree of independence in the community; and

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

## **15. RESPONSIBILITIES OF THE GEM PSYCHIATRIC PROVIDER**

The GEM Psychiatric Provider, (e.g., psychiatrist, psychiatric advanced practice nurse, etc.) is responsible for:

a. Assessing and contributing to the diagnosis, treatment, and the development of plans of care for patients with combined medical-psychiatric, mixed cognitive, affective, substance dependence, 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, families, and caregivers regarding the assessments, treatment, and management of biopsychosocially complex cases.

## **16. RESPONSIBILITIES OF THE GEM PSYCHOLOGIST**

The GEM Psychologist is responsible for:

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

b. Alerting the 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 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 in assisting in resolving interpersonal conflicts and streamlining function within the GEM team.

## **17. RESPONSIBILITIES OF THE GEM DIETITIAN**

The GEM Dietitian is responsible for:

a. Performing nutritional assessments and contributing to the 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.

## **18. 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 the 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, incompatibilities, or redundant or unnecessary medications;
- d. Participating in ongoing education of the GEM staff, particularly physicians and nurses, regarding drug problems in older people; and
- e. Providing patient and family education regarding medications and compliance with prescribed drug regimen.

## **19. RESPONSIBILITIES OF THE GEM DENTIST**

The GEM Dentist is responsible for:

- a. Screening GEM inpatients and outpatients for oral and oropharyngeal disease and dysfunction, including an assessment of any oral appliances;
- b. Providing a 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 (this last may be delegated to other suitably-trained Dental Service personnel)

## **20. 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 or maintain GEM patients' functioning;

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

d. Educating GEM staff, patients, and caregivers regarding rehabilitation needs and management of GEM patients.

## 21. SELECTING APPROPRIATE PATIENTS

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. 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. Inclusionary criteria varies depending on the presence or absence of other services offered by the health care system of which the GEM is a part, because the need-focused nature of GEM permits it to fulfill a range of vacant clinical niches (e.g., to offer palliative care in the absence of an inpatient palliative care program).

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, or psychosocial problems, and 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 or 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) 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.

(c) In the absence of depression or cognitive impairment, demonstrate a lack of motivation or have a documented refusal to participate in an 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 as follows, needs to be regarded as guidelines that are applied only as appropriate to the health care system.

#### (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, 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 or falls, malnutrition, or depression.

(b) For programs that have a strong focus on health promotion and disease prevention, the inclusion criteria may 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:

(a) Homebound and might best be managed by other services, such as HBPC; or

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

## 22. STRUCTURE OF THE GEM PROCESS

a. **Evaluation Process.** The geriatric evaluation begins with a comprehensive geriatric assessment (CGA), in which team members obtain a detailed medical, psychosocial, and medication history. This is reviewed by the interdisciplinary team alongside the findings of the current, full physical, psychological, and functional assessments coupled with evaluations of the support, dietary, and living situations; and clarifications of patient and family or caregiver expectations. In this way, a current and complete problem list and the interdisciplinary plan of care is developed, thereby completing the evaluation process.

(1) **Initial Stage of the Assessment.** Patients referred to the GEM Program are likely to differ in the number and complexity of their health-related problems; therefore, their need for specialized assessments. This is especially true of outpatient GEMs that include a health promotion and disease prevention focus. Consequently, programs may differ in the core group of health professionals involved in the initial phase of the assessment of GEM referrals, and in the structure and components of this first-phase or basic assessment. This might include the administration of specific screening instruments, as well as the completion of a detailed history and physical exam. Additional assessment components and additional health-related professionals may be needed in the assessment of a given patient who completes the basic stage. In this way, the CGA process can be tailored to the needs of each individual patient, although everyone must complete certain basic components. *NOTE: Specific assessment instruments, that have been validated and are widely available, are cited in paragraph 25 (see subpars. 25m, 25n, and 25o).*

(2) **In-depth Assessment Tailored to the Individual Patient.** The timeframe in which, and mechanism by which, all of the needed assessment 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 assessments are shared by the core team must be defined, as well as who is (are) responsible for synthesizing the results into an appropriate management plan, in order to complete the evaluation component of the GEM process. 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.

b. **Management Process.** Once the assessment is complete the implementation of the plan of care begins.

(1) In an inpatient setting, this is customarily undertaken by the team members who contributed to the original assessment, with periodic reassessment and adjustment of the plan of care as deemed necessary and appropriate.

(2) In an outpatient setting, several approaches to management have emerged because of the disparity between the large number of elderly Veterans for whom geriatric evaluation is indicated on the one hand, and the limited number of clinicians with specialty-level expertise in geriatrics on the other:

(a) The team may decide to restrict its activities to evaluation only; i.e., assessment and development of the interdisciplinary plan of care. The management recommendations are then communicated to the primary care provider to carry out. *NOTE: The published literature reflects poor compliance with such recommendations and outcomes that are not substantially improved when geriatric evaluation is performed on a consultative basis, without implementation of the plan of care by the GEM team (see subpar. 23k). This approach is therefore discouraged.*

(b) The team may select 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.

(c) The team may accept the growing workload with an expectation that needed staff adjustments will be made to keep pace with the clinical load. This approach is generally adopted at larger academic centers where there is abundant and regularly renewed geriatrics expertise.

c. **Focus on the Family or Caregiver.** The patient's family 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 or caregivers. The extent of this evaluation needs to be tailored to the needs of the individuals involved. Likewise, the management component must also include efforts to partner with the family or caregivers as appropriate. This can be done through such means as:

- (1) Providing moral support, training, and education resources;
- (2) Addressing questions and concerns;
- (3) Making referrals for respite and home services when necessary; or
- (4) Giving guidance on navigating through appropriate health care and social support systems.

### **23. PROGRAM EVALUATION AND PERFORMANCE IMPROVEMENT**

a. Program evaluation and performance improvement activities are vital components of GEM program function; adequate staff time must 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) Reduced episodes of Emergency Room utilization;
  - (d) Reduced hospitalizations;
  - (e) Improvement in physical or psychosocial functioning, with the exception of those patients with a diagnosis indicative of progressive decline;
  - (f) Improvement in medication utilization;

- (g) Establishment of coordinated interdisciplinary care plans;
- (h) Facilitation of geriatric education and research.
- (i) Interdisciplinary involvement in regularly scheduled team meetings;
- (j) Establishment of patient-centered goals of care;
- (k) Patient and family satisfaction with care;
- (l) Formulation of end-of-life care plans; and
- (m) Increased coordination with community programs and services.

(2) Techniques for monitoring these program objectives 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: the number, disciplines, and origins of trainees, number of hours, changes in attitudes, behaviors, and 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 need to be coordinated with the facility research office and research review committees.

## 24. STAFF TRAINING

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

a. **Local Resources.** Ongoing training needs to 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 providing opportunities for ongoing professional enrichment through exchange of ideas locally, regionally and nationally.

b. **Other VA Medical Centers.** Inter-facility educational details need to be employed to observe the functions of established GEM Programs. *NOTE: It is 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 staffs serve as an excellent resource to:

- (1) VA medical centers establishing new GEM programs,
- (2) Those seeking outside evaluation of their existing programs, or
- (3) Those considering changes in their current GEMs.

d. **Non-VA Resources.** Where available, geriatric personnel need to 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.

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**REPORTING WORKLOAD FOR “GERIATRIC EVALUATION” WITH HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS) CODE, S0250**

Geriatric evaluation is a service that Public Law 106-117 specified for inclusion in the Veterans benefit package. For the purposes of program planning, standardization of services, and reporting to stakeholders, a mechanism for reporting this workload, whether delivered in an inpatient or outpatient setting, has been developed and is described in the following.

1. Geriatric evaluation is recorded with a Health Care Procedure Coding System (HCPCS) code, S0250, which is defined as “Comprehensive geriatric assessment and treatment planning for a patient with multiple chronic diseases characteristically encountered in persons of advanced age, made individually complex by one or more functional and psychological factors, performed by an assessment team.”

2. For the purposes of tracking geriatric evaluation workload in the Department of Veterans Affairs (VA), the “assessment team” must be comprised of no fewer than three clinicians.

a. One of these must be an independent licensed provider (usually a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner, or Physician Assistant) who has advanced training, certification, or prior supervised clinical experience in managing the health needs of geriatric and other chronically disabled patients whose cases are made additionally complex by psychosocial or environmental factors.

b. The other two disciplines most commonly involved are nursing and social work. Other disciplines commonly involved include: pharmacy, physical therapy, occupational therapy, psychology, and dietetics.

3. “Geriatric evaluation” may be delivered in either inpatient or outpatient settings. The specific workload reporting procedure varies depending on the setting.

a. **Outpatient Settings.** Outpatient settings that may include geriatric evaluation include: Outpatient Geriatric Evaluation and Management (Stop Code 319, either position), Geriatric Primary Care (350, either position), GRECC clinic (352, either position), Geriatric Clinic (318, either position), Primary Care Clinic (323, either position), Alzheimer’s or Dementia Clinic (320, either position), Home-Based Primary Care Clinics (170-177, primary only) and others. It must be stressed that while geriatric evaluation may be provided in these settings, not all episodes of care in these settings will include geriatric evaluation, and only an episode of care that does so is to be documented as such.

(1) To record an episode of geriatric evaluation for an outpatient, the record of the encounter entered by the licensed independent provider must include the HCPCS code S0250 and specify the other two clinicians of different disciplines participating in the process.

(a) The S0250 workload is not to be reported until all individuals involved in developing the interdisciplinary plan of care have completed their contributions to the process. In the event the process extends beyond a single appointment, the time span between the first assessment and

finalization of the plan of care needs to be as brief as possible (generally a week or less) in order to ensure that the status of the patient has not changed substantially in the meantime. When the evaluation process extends over more than a single day, but the independent licensed provider has entered the S0250 after completing that part of the assessment, a note describing the full plan of care needs to be made as an addendum to the licensed independent provider's original note, once all the assessments have been completed and the interdisciplinary plan of care has been developed.

(b) In the event more than one encounter form is generated in the course of the assessments (e.g., each provider completes one), only the encounter form completed by the independent provider is to include the S0250 code.

(c) Individual disciplines' assessments and recommendations may be recorded in the health record in several ways, including:

1. Independent progress notes detailing each assessment, with the final plan specifying the dates, authors, and disciplines of each relevant assessment;

2. A single note summarizing the different assessments and the resulting interdisciplinary plan of care, and specifying the identities and disciplines of the contributors and the dates of the individual assessments; or

3. Notes completed by representatives of different contributing disciplines as "addenda" to a "parent note" that contains the plan of care (see VHA Handbook 1907.01).

(2) Geriatric evaluation provided in HBPC must not be reported with the S0250 code. Every HBPC admission counts as a single episode of geriatric evaluation and adding the S0250 code to an HBPC encounter diminishes the accuracy of local, regional, and national geriatric evaluation workload data.

b. **Inpatient Settings.** Inpatient settings that may include provision of geriatric evaluation include: Inpatient GEM Programs and CLC. Inpatient GEM is most commonly located within CLC and is coded with Treating Specialty (TRT) 81, CLC GEM Nursing Home Care. Inpatient GEM also may be located within acute care units, in which case the Treating Specialty is 31 (GEM Acute Medicine), 32 (GEM Intermediate Care), 33 (GEM Psychiatric Bed), 34 (GEM Neurology-was used prior to FY 06), or 35 (GEM Rehabilitation Medicine). If geriatric evaluation is part of the service provided to Veterans staying in the CLC (but not in a dedicated GEM TRT that is part of the CLC), the Treating Specialty will be one of those described in current VHA policy. In the event geriatric evaluation is provided as a component within a GRECC inpatient clinical demonstration activity, one of the GRECC TRTs will apply. The GRECC TRTs are listed as 1A (GRECC CLC Short Stay), 1B (GRECC CLC Long Stay), 1C (GRECC GEM CLC Short Stay), 1D (GRECC GEM Rehab), and 1E (GRECC MED) (or 100-104). It must be stressed that while geriatric evaluation may be provided in any of these settings, not all episodes of care in these settings will include geriatric evaluation, and only an episode of care that does so is to be documented as such.

(1) To record an episode of geriatric evaluation for an inpatient, an inpatient encounter must be generated that includes the S0250 HCPCS code and the names of at least two individuals from different disciplines, in addition to the licensed independent provider, involved in developing the interdisciplinary plan of care.

(a) The service most likely to record geriatric evaluation workload (e.g., Extended Care or Geriatric Medicine) needs to initiate a collaboration with local Information Technology personnel (e.g., their Clinical Applications Coordinator, DSS Site Manager or DSS Clinical Coordinator, Health Information Management representative, etc.) to customize users' CPRS templates, clinics, procedures, and Evaluation and Management (E&M) codes options (including creation of a "proxy clinic," i.e., a "virtual" entity that will accept procedure codes without generating actual outpatient clinical workload).

(b) The S0250 workload is not to be reported until all individuals involved in developing the interdisciplinary plan of care have completed their contributions to the process. The time span between the first assessment and finalization of the plan of care needs to be within the particular ranges specified by local policy or accreditation requirements, whichever is more stringent.

(2) Individual discipline's assessments and recommendations may be recorded in the medical record in several ways as detailed in preceding subparagraph 3a(1)(c)1, 3a(1)(c)2, and 3a(1)(c)3.