Infusing Gerontologic Practice Into PACT

Jenice Ria S. Guzman-Clark, PhD, GNP-BC; Bobbie Sue Oglesby Johnson, DNP, FNP-BC; Mary E. Mather, MSN, RN-BC, CNL, VHA-CM; and Hadiya A. Williams, MSN, AGPCNP-BC

Care that recognizes the specific challenges facing older veterans is important for improving their care. Fortunately, a growing number of tools and resources are available to all members of the Patient Aligned Care Team.

The older adult population in the VA is growing. Adults aged > 85 years are the fastest growing segment of the older veteran population and many are afflicted with multiple medical problems and functional impairments.[1,2] The majority of older veterans (94.6%, or about 1.9 million veterans) who seek care at the VA obtain care through primary care providers (PCPs) who are often not formally trained in geriatrics.[1,3] With the increasing number of older patients, new models of care are needed to provide coordinated, comprehensive, efficient, and patient-centered care.[4,5]

Common themes found in successful models of care for older patients include a team approach, care management (comprehensive and coordinated), and patients who are active partners.[4] These themes are reflected in the VA Patient Aligned Care Team (PACT) primary care program. PACT, a model of care that was initiated in 2010 and is built on a foundation of patient-centered care, encompasses a team approach to provide comprehensive, coordinated, and personalized care.[6-8] The challenge for the VA is to integrate gerontologic principles and tools into the daily practice of all PACTs in order to improve care provided for older veterans.[9]

This article discusses current challenges in caring for older veterans in the VA system and recommends tools that can be used to infuse geriatric care principles into VA primary care by the PACT, to improve the quality of care provided to older veterans. In addition, the article also describes VA geriatric programs that PACT clinicians can access to supplement older veterans' care.

CHALLENGES OF CARING FOR OLDER VETERANS

One concern when caring for older veterans arises when the veteran accesses both VA and non-VA health care services to offset medication costs and obtain services not covered by Medicare or other insurance companies.[2,3] This "dual care" can exacerbate polypharmacy issues and increase confusion regarding plans of care. Problems may arise when multiple providers from different systems of care prescribe medications available only within their own formulary and/or order diagnostic and laboratory tests with results available only within their own health care system.

The VA is also challenged by health care delivery for rural veterans. Thirty-six percent of all veterans live in rural areas, and they often depend on non-VA services to meet their health care needs due to difficulty traveling to the nearest VA facility.[10] Seasonal residency also presents challenges. An increasing number of older veterans are seen at different VA facilities when they "winter" in a different section of the country.

Fortunately, a VA provider in one facility can access a patient's electronic medical records in another facility, using the VA Computerized Patient Record System (CPRS). However, it is unclear to what extent busy VA PCPs use this function when seeing patients. Although individual pilot programs have shown promise, integrated electronic health records

Dr. Guzman-Clark is a gerontologic nurse practitioner and nurse researcher at the VA Greater Los Angeles Healthcare System, Geriatric Research Education and Clinical Center, Los Angeles, California; the clinical nurse advisor for the VA Office of Nursing Services, Geriatrics and Extended Care Field Advisory Committee; and an assistant clinical professor at the UCLA School of Nursing in Los Angeles. **Dr. Johnson** is a family nurse practitioner at the Hunter-Holmes McGuire VAMC in Richmond, Virginia and adjunct faculty at South University in Glen Allen, Virginia. **Ms. Mather** is a nurse manager at the Primary Care South Texas Veterans Health Care System. **Ms. Williams** is a nurse practitioner at the Ralph H. Johnson VAMC in Charleston, South Carolina.

between VA and non-VA health care have not advanced to the point of sharing data or reconciling care plans (R. Rupper, personal communication, March 1, 2013).

Many PCPs and other PACT staff are not formally trained in geriatrics and may have had limited exposure to geriatric principles.[3] Clinic time pressures, multiple clinical reminders (eg, vaccinations), and panel management of specific diseases make it challenging to find time to focus on complex geriatric syndromes. Current PACT performance measures also do not routinely include geriatric-specific quality of care criteria or focus on patient function (K. Shay, personal communication, February 12, 2013), a hallmark of geriatric care.[8] Furthermore, with increasing complexity of the health care system and limited availability of resources, it is often time consuming to identify and collaborate with non-VA resources to ensure patients' needs are met in their communities.

OPPORTUNITIES FOR IMPROVEMENT IN CARE

The VA transformation to PACTs has led to process changes in clinic workflow that may aid in addressing the aforementioned challenges in caring for older veterans. Each patient is assigned to a PCP-led team that includes a registered nurse care manager, a clinical associate, and an administrative associate. The PACT model of care has increased access to care by redesigning face-to-face visits, increasingly moving toward open access, and through the increased use of virtual access via secured e-mail, telephone visits, and telehealth.[8]

In addition to process changes, the VA has created new tools to assist teams in patient management. One of these is the Care Assessment Need (CAN) score, a risk stratification tool available for use by PACTs to identify patients at highest risk for hospital admission and/or death for focused care management.[11] It is based on statistical prediction models of veterans enrolled in primary care, using patient characteristics and health care use information.[11] Although the CAN score looks promising, more research is needed to evaluate its effectiveness in improving care for older veterans and its association with better patient functioning—an important focus in quality geriatric care.

A tool that takes into account daily function is the Vulnerable Elders Survey-13 (VES-13). As measured by the VES-13, functional ability has been shown to be a strong predictor of decline and death in older adults independent of gender or comorbidities.[12] Integration of the VES-13 into the evaluation of older veterans could assist PACTs in considering patients' current function and life expectancy in their care plans along with patient and family goals.

Another potentially useful tool for the PACT team is the SPICES mnemonic (Sleeping, Problems with feeding/eating, Incontinence or urinary problems, Confusion, Evidence of falls, and Skin breakdown).[13] Although SPICES is not comprehensive, this mnemonic highlights potential problems facing older patients that may not be brought up routinely. It provides a concise, formalized format that can be used by clerks or patient support assistants as part of the check-in process.

This tool has been used successfully by the Geriatric Evaluation and Management Clinic of the South Texas Veterans Health Care System (STVHCS) to improve communication between the PCP and nurse so that pertinent patient information is relayed concisely. SPICES was helpful in identifying patients needing interventions for fall risk. In a retrospective chart review of 100 randomly selected patients aged 75 to 90 years enrolled in the clinic, a 75% reduction in falls was noted during the first year of implementation (STVHCS unpublished data, 2012).

Additional tools that focus on identifying specific geriatric syndromes are available online from the Hartford Institute for Geriatric Nursing, which provides evidence-based information and training on how to assess, evaluate, and manage common geriatric syndromes such as depression, dementia, and delirium.[14] The site also includes videos on how to use common brief geriatric assessment tools that can be performed by nurses and health care associates while the patient is in the waiting room. Though promising, further research is needed to study the effects of these tools on patient, provider, and system outcomes.

Infusing quality of care indicators (QI) can play an integral role in achieving PACT goals while improving the older veterans' quality of life. For example, polypharmacy and medication-related injuries in older adults continue to pose both a safety and economic challenge to patients and the health care system.[15-17] The 2012 Beers criteria for Potentially Inappropriate Medications in Older Adults lists 53 medication classes that have been identified as potentially inappropriate medications for use in older adults.[17] Use of this tool by PACTs in the development of patient care plans has the potential to reduce medication-related adverse reactions and improper prescribing.[18,19]

Assessing Care of Vulnerable Elders (ACOVE) also provides QIs that are specific to vulnerable older persons.[20-24] The most recent version, ACOVE-3, includes 392 QIs for 26 conditions and 14 types of care

processes and covers all domains of care.[20] Findings from a study applying QIs involving vulnerable elderly patients in 2 managed care programs revealed that recipients of better-quality care had a 10% higher survival rate over 3 years.[25]

The VA currently monitors 6 frail elderly QIs based on ACOVE criteria via reviews of medical records in veterans aged > 75 years. These QIs cover falls, incontinence, functional assessment, and the presence of a surrogate decision maker. PACT staff, unfortunately, do not receive feedback on these, because they are still QIs and not part of the performance measures (K. Shay, personal communication, February 12, 2013). Though some VA sites have adopted these QIs to some extent, until these frail elderly QIs become performance measures throughout VA, other competing priorities may be more at the forefront of quality improvement projects done by PACT teams.[5]

The American Geriatrics Society recently published recommendations on the care of older adults with multiple chronic conditions, to aid PCPs in practicing a more individualized, patient-centered care in complex cases.[26] In addition to focusing on a patient's primary concern during a clinic visit and eliciting preferences, considering prognosis in deciding on treatment options allows patients to better weigh the potential benefits and burdens in their daily living.[26] A discussion on how aggressive potential treatments are and what the patient is willing to undertake is an important component of patient-centered care and should be incorporated during routine PACT clinic visits.

VA GERIATRIC PROGRAMS

It is important for PACT clinicians to be familiar with the geriatric programs and resources available within the VA medical home "neighborhood," which can supplement care. One such resource is the Geriatric Research Education and Clinical Centers (GRECCs). There are currently 19 GRECCs throughout the nation that serve as Centers of Excellence in the care of older veterans.[27] The GRECCs provide training for clinicians, test innovative ways to care for older veterans, and collaborate with other staff to improve the care provided. Some have also developed Geriatric Primary Care Clinics (or Geri PACTs) to provide team care to very frail and high-risk older veterans. Since not all VA facilities have access to Geri PACTs, the GRECCs play an important role in making geriatric expertise and training available to the PACTs.[3]

To address this limitation in access, VA programs have begun using telehealth technology to increase competencies of PCPs in caring for older veterans. For example, the VA Geriatric Scholars Program is a national educational program with different avenues to "geriatricize" VA primary care services and improve knowledge and care provided to older veterans.[28] It consists of several subprograms: Geriatric Scholars Program for Rural Community Based Outpatient Clinics; Geriatric Scholars Program for Primary Care Providers; Rural Interdisciplinary Team Training; and the Geriatric Assessment Pocket Guide.[29] These components may include didactics both face-to-face and online, clinical experience with performing common geriatric screening tools, and a quality improvement project.

Some local VAMCs have also developed programs to address this need to improve care provided to older veterans in PACT. The VA Greater Los Angeles Healthcare System (GLA) GRECC, for example, has started several programs to infuse geriatrics into PACTs, including the Geri Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). VA SCAN-ECHO was developed to increase access to specialty care in rural/underserved areas. The PCP presents a case and a specialty provider gives guidance in the assessment and/or management of a specific clinical problem.[30] Unlike many other SCAN-ECHO programs, the GLA Geri SCAN-ECHO program encourages not only PCPs, but also nurses and social workers to submit consults for discussion and encourages team management (a hallmark of quality geriatric care). Another important GLA GRECC project is the Veterans Cognitive Assessment and Management Program (V-CAMP), which uses videoconferencing to assess and manage veterans with cognitive impairment/dementia who reside in underserved areas in the GLA region. The program provides dementia care management and access to neuropsychological examinations—services that are often not available in rural areas.[31]

Various VA program offices have also published useful resources to help PACT clinicians infuse gerontologic principles into their practice. The VA Office of Nursing Services has a Geriatrics and Extended Care Field Advisory Committee, which recently produced on-demand lectures in the virtual VA eHealth University (also known as myVeHU campus) on improving the PACT's management of progressive chronic diseases and dementia recognition and initial evaluation. They also produced a resource guide for VA clinicians (nursing and non-nursing), based on a team consensus of what the workgroup thinks a clinician would find helpful in clinical practice to improve

care of older veterans. The VA Office of Geriatrics and Extended Care Service also identified a list of clinical and educational resources to help PACT clinicians. These include the Geriatrics Evaluation and management (GEM) Tools Booklet (http://geriatricscareonline.org) and a SharePoint site to improve dementia care in all settings.

The VA Office of Geriatrics and Extended Care provides additional geriatric-specific programs (http://va.gov/geriatrics). These programs may be useful for consultation and collaboration for patients whom the PACT teams have found to be more challenging and require more assistance to meet performance measures and patient needs. A recent evidence synthesis notes that direct involvement of geriatricians (as opposed to indirect care with limited contact) is more likely to result in positive patient outcomes and should be considered for those patients who are the most frail and/or high utilizers of services.[32]

CONCLUSION

The PACT initiative in the VA health care system may prove to be an important vehicle for improving and standardizing the care provided to older veterans. Use of reliable and valid tools in the identification and assessment of geriatric syndromes, provision of quality standards, and use of innovative telehealth practices are promising enhancements for the primary care of older veterans. ●

Acknowledgements

We would like to thank the following contributors for their thoughtful review of the initial drafts of this article: Dr. Balmatee Bidassie; Dr. Kathryn Corrigan; Dr. Gail McNut; Dr. Linda Kinsinger, chief consultant for preventive medicine in the Office of Patient Care Services; Dr. Theodore Hahn, GRECC deputy director from VA Greater Los Angeles Healthcare System; Dr. James Hallenbeck, associate chief of staff, Extended Care at VA Palo Alto Health Care System; Ms. Storm Morgan, VA Office of Nursing Services PACT program manager; and Dr. Kenneth Shay, director of Geriatric Programs for the VA Office of Geriatrics and Extended Care.

The authors also would like to express their gratitude to the VA Office of Nursing Services, Clinical Practice Program, Geriatrics and Extended Care Field Advisory Committee for the opportunity to work on this manuscript.

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, *Frontline Medical Communications Inc., the U.S. Government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review the complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*

REFERENCES

1. U.S. Department of Veterans Affairs. Geriatric Ambulatory Care. VHA Handbook 1140.10. U.S. Department of Veterans Affairs Website. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2202. Published April 26, 2010. Accessed September 29, 2014.
2. Federal Interagency Forum on Aging-Related Statistics. Older Americans 2012: Key indicators of well-being. AgingStats.gov Website. http://www.agingstats.gov/agingstatsdotnet/main_site/default.aspx. Accessed September 29, 2014.
3. Shay K, Schectman G. Primary care for older veterans. *Generations.* 2010;34(2):35-42.
4. Institute of Medicine. Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: *The National Academies Press;* 2008.
5. Shay K, Hyduke B, Burris JF. Strategic plan for geriatrics and extended care in the veterans health administration: Background, plan, and progress to date. *J Am Geriatr Soc.* 2013;61(4):632-638.
6. Berenson RA, Devers KJ, Burton RA. Will the patient-centered medical home transform the delivery of health care? Timely analysis of immediate health policy issues. Urban Institute Website. http://www.urban.org/uploadedpdf/412373-will-patient-centered-medical-home-transform-delivery-health-care.pdf. Published August 2011. Accessed September 29, 2014.
7. U.S. Department of Veterans Affairs. VA Primary Care Services. Patient-centered medical home model concept paper. U.S. Department of Veterans Affairs Website. http://www.va.gov/health/services/PrimaryCare/docs/pcmh_ConceptPaper.doc. Accessed October 7, 2014.
8. VA Undersecretary for Health. What is PACT? U.S. Department of Veterans Affairs Website http://www.va.gov/health/services/primarycare/pact/index.asp. Updated February 18, 2014. Accessed October 7, 2014.
9. Askari M, Wierenga PC, Eslami S, Medlock S, de Rooij SE, Abu-Hanna A. Assessing quality of care of elderly patients using the ACOVE quality indicator set: A systematic review. *PLoS ONE.* 2011;6(12):e28631.
10. U.S. Department of Veterans Affairs. Office of Rural Health. About the office of rural health. U.S. Department of Veterans Affairs Website. http://www.ruralhealth.va.gov/about/index.asp. Update June 12, 2014. Accessed October 10, 2014.
11. Schectman G, Stark R, Fihn S, VanEe H, Box T. Care assessment need score: A tool for care management. Presented on March 29, 2012. http://www.myvehucampus.com/#loc=auditoriumRoom. Accessed October 14, 2014.
12. Min L, Yoon W, Mariano J, et al. The vulnerable elders-13 survey predicts 5-year functional decline and mortality outcomes in older ambulatory care patients. *J Am Geriatr Soc.* 2009;57(11):2070-2076.
13. Fulmer T, Wallace M. Fulmer SPICES: An overall assessment tool for older adults. http://consultgerirn.org/uploads/File/trythis/try_this_1.pdf. Revised 2012. Accessed October 1, 2014.
14. Hartford Institute for Geriatric Nursing. ConsultGeriRN.org Website. http://consultgerirn.org. Accessed September 30, 2014.
15. Opondo D, Eslami S, Visscher S, et al. Inappropriateness of medication prescriptions to elderly patients in the primary care setting: A systemic Review. *PLoS One.* 2012;7(8):e43617.
16. Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH. Updating the Beers criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. *Arch Intern Med.* 2003;163(22):2716-2724.
17. The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers criteria for potentially inappropriate medication use in older adults. *J Am Geriatr Soc.* 2012;60(4):616-631.
18. Higashi T, Shekelle PG, Solomon DH, et al. The quality of pharmacologic care for vulnerable older patients. *Ann Intern Med.* 2004;140(9):714-720.
19. Lund BC, Steinman MA, Chrischilles EA, Kaboli PJ. Beers criteria as a proxy for inappropriate prescribing of other medications among older adults. *Ann Pharmacother.* 2011;45(11):1363-1370.
20. RAND. Assessing care of vulnerable elders. Quality indicators- ACOVE 3. RAND Website. http://www.rand.org/health/projects/acove/acove3.html. Accessed October 7, 2014.

21. Wenger NS, Shekelle PG. Assessing care of vulnerable elders: ACOVE project overview. *Ann Intern Med.* 2001;135(8, pt 2):642-646.
22. Shekelle PG, MacLean CH, Morton SC, Wenger NS. Assessing care of vulnerable elders: Methods for developing quality indicators. *Ann Intern Med.* 2001;135(8, pt 2):647-652.
23. Reuben DB, Roth C, Kamberg C, Wenger NS. Restructuring primary care practices to manage geriatric syndromes: The ACOVE-2 intervention. *J Am Geriatr Soc.* 2003;51(12):1787-1793.
24. Wenger NS, Roth CP, Shekelle P; ACOVE Investigators. Introduction to the assessing care of vulnerable elders-3 quality indicator measurement set. *J Am Geriatr Soc.* 2007;55 (suppl 2):S247-S252.
25. Higashi T, Shekelle PG, Solomon DH, et al. The quality of pharmacologic care for vulnerable older patients. *Ann Intern Med.* 2004;140(9):714-720.
26. American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Patient-centered care for older adults with multiple chronic conditions: A stepwise approach from the American Geriatrics Society. *J Am Geriatr Soc.* 2012;60(10):1957-1968.
27. U.S. Department of Veterans Affairs. Geriatric Research Education and Clinical Centers. GRECC. U.S. Department of Veterans Affairs Website. http://www.va.gov/GRECC/index.asp . Updated August 17, 2012. Accessed October 10, 2014.
28. Tumosa N, Horvath KJ, Huh T, et al. Health care workforce development in rural America: When geriatrics expertise is 100 miles away. *Gerontol Geriatr Educ.* 2012;33(2):133-151.
29. U.S. Department of Veterans Affairs. Geriatric Research Education and Clinical Centers. The VA Geriatrics Scholars Program. U.S. Department of Veterans Affairs Website. http://www.va.gov/GRECC/GRECC_Educational_Events_and_Products.asp. Updated February 21, 2013. Accessed October 1, 2014.
30. U.S. Department of Veterans Affairs. Office of Public and Intergovernmental Affairs. VA uses technology to provide rural veterans greater access to specialty care services. U.S. Department of Veterans Affairs Website. http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2353. Updated July 10, 2012. Accessed October 1, 2014.
31. Harrell KM, Wilkins SS, Connor MK, Chodosh J. Telemedicine and the evaluation of cognitive impairment: The additive value of neuropsychological assessment. *J Am Med Dir Assoc.* 2014;15(8):600-606.
32. Totten A, Carson S, Peterson K, Low A, Christense V, Tiwari A. Evidence brief: Effect of geriatricians on outcomes of inpatient and outpatient care, VA-ESP Project #09-199. U.S. Department of Veterans Affairs Website. http://www.hsrd.research.va.gov/publications/esp/Geriatricians.pdf. Accessed October 1, 2014.